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ABSTRACT

Eight papers examine issues in providing special education services to young native American handicapped children. B. Ramirez and J. Walker ("Background, Rationale, and Overview to Early Childhood and Special Education Services for Indian and Alaska Native Children'" consider the needs of young children as well as such special program aspects as culture and tribal involvement. In "Strategies for Screening, Assessment, and Diagnosis," W. Swan and J. Walker discuss principles and systems for meeting federal requirements in child evaluation programs. G. Weaver ("Planning for Individual Child Services'" reviews the development and content of individualized education programs (IEPs). Four levels of parent involvement are identified by M. Johnson, "Parental Involvement: A Vital Preschool Program Component." Advantages and disadvantages of different service delivery systems are focused on by J. Caldarera and L. Guidera in "Planning for and Implementing Specialized (or Related) Services." Twenty-one brief program descriptions are presented by D. Ridgley ("Selected Programming Alternatives for Serving Young Handicapped Children')" P. Trohanis provides guidelines for "Designing an Inservice Training Program." In the final paper, "Managing the Planning and Implementation of Preschool Programs," P. Trohanis reviews the use of problem solving and decision making processes, discusses preplanning activities, considers the impact of overall philosophy and goals, and describes program operation according to 10 components. Among seven appendixes are a sample IEP and a sample interagency agreement. (CL)

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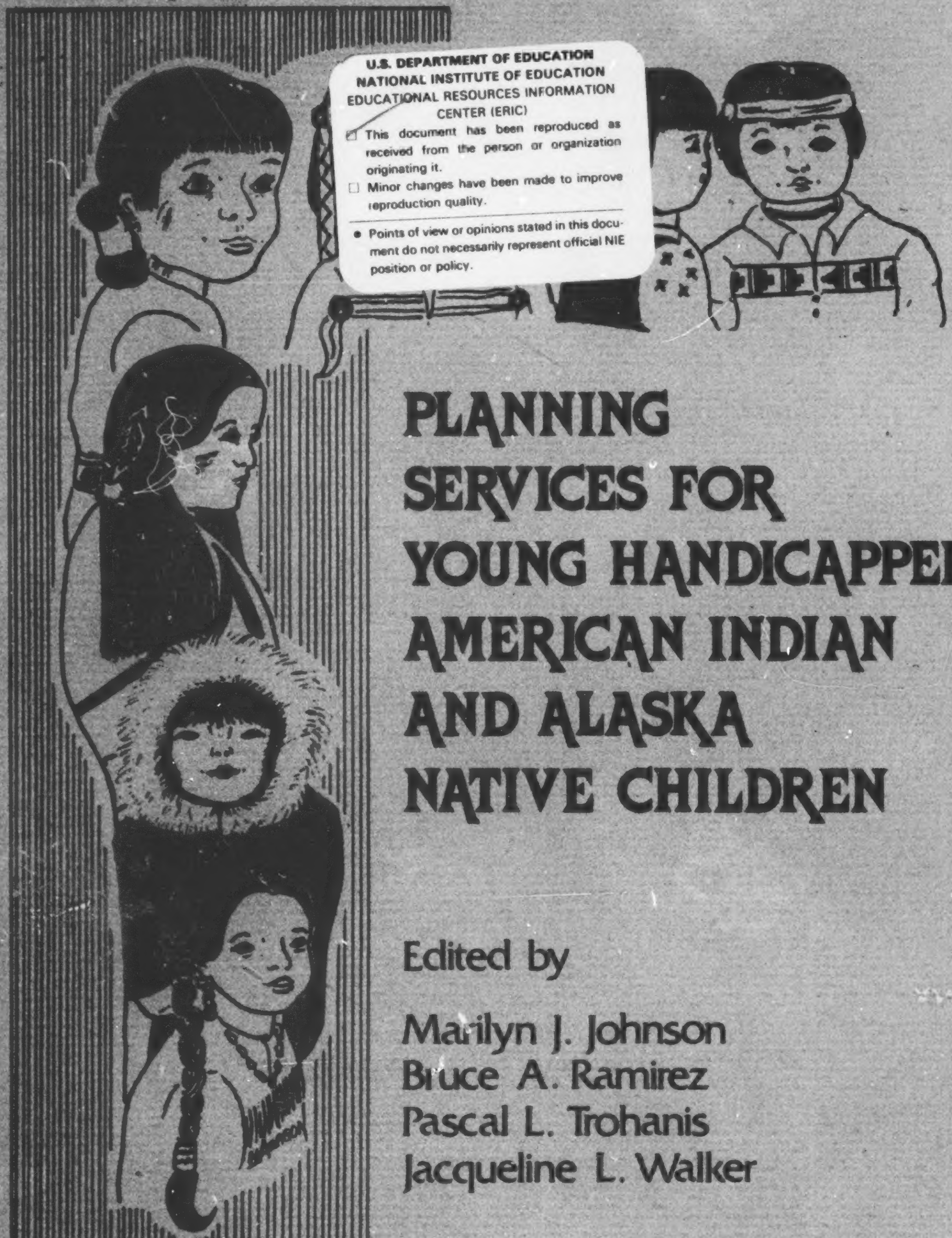

PLANNING SERVICES FOR YOUNG HANDICAPPED AMERICAN INDIAN AND ALASKA NATIVE CHILDREN

Edited by

Marilyn J. Johnson
Bruce A. Ramirez
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FOREWORD

In the past twenty-five years, education for both handicapped and very young children has increased dramatically. This has happened mainly because parents and others began to work through the legal system to ensure that the constitutionally guaranteed right to education for their children was available. And while many handicapped preschoolers from a variety of cultural backgrounds have benefitted from the tenacity of these parents through the years, other children remain still somewhat neglected. One group of children, in particular, has found it difficult to obtain needed assistance: the Native American. (This group includes Alaskan Aleuts, Eskimos and American Indians.)

The reasons for this gap in services are multiple: the group is relatively small; it is linguistically diverse; it is largely isolated from urban areas; few of the evaluation materials developed for other groups and used to determine what services are needed are appropriate; and, the various agencies that share responsibility for educating these children have not been able to agree on responsibilities. The cumulative effect of all these facets of the Native American situation has been to baffle special education efforts in general.

Numbers. According to census figures for 1970, approximately 100,000 children under five years of age belonged to the Native American group. Of these, approximately 20,000 were classified as handicapped. Only 23 percent of these were receiving any services in 1975.

Languages. Among the Native American groups, there are over 250 different languages. Given the small size of the total handicapped population, it is quite possible that a very small number of children needing services may speak one of the more obscure languages. The difficulty of accurately evaluating such children is monumental.

Materials and Professionals. Needless to say, evaluation and curriculum materials have not been translated into every one of the existing languages. Moreover, because training opportunities have been scarce, few specialists from Native American backgrounds are available to speed services to the various tribes and villages.

Accessibility. The specialized services and the professionals who provide them are also often in urban or, at least, geographically accessible regions. Yet, the Native American population is frequently found in isolated areas fraught with rugged terrain and adverse climatic conditions.

Service Providers. On top of all these other difficulties, the agencies charged with serving this group many times cannot agree on who should be responsible for the children in a given situation. So, some children and families never receive services.

Even with all of these dilemmas, ways must be found to offer a sound education to these children. In this book, we have set out to describe the central problems, historically and presently, and to explore alternative plans for correcting these problems. This is a book with ideas on where to find money, materials and personnel; on how to train professionals and paraprofessionals to work with Native American children effectively; on how to work with families and parents in particular. It provides information on the agencies which may be helpful and the kinds of services they provide. Finally, the book offers ideas on organizing and managing preschool programs and the diagnosis and assessment of the children who come into them.

In short, it is a book with ideas and information on many different fronts. Doubtless, there are themes which should have been addressed in more depth. And there are areas that are not covered at all, but should have been. We have tried, nonetheless, to touch on all areas that concern young handicapped children and their education in general. And we have tried to make this general information specific for the native American's situation. As Haskins and Stifle write,

> There is much that those concerned with alleviating the difficulties of the handicapped Native American can learn from those who pioneered in the field of handicapped rights. But because of the many ways in which life on the Indian reservation [or Alaskan village] differs from the mainstream of American society, the Native American will have to adapt what he learns to his own special needs, and explore altogether new solutions to his unique situation (p. 14, he will lift up his head).

The Editors
August, 1980

CHAPTER 1

Background, Rationale, and Overview to Early Childhood Special Education Services for Indian and Alaska Native Children by ***Bruce A. Ramirez and Jacqueline L. Walker***

INTRODUCTION

Over the past decade, interest has grown at all governmental levels in the development of early intervention programs for preschool children in the United States. While many of these programs and services initially centered on economically disadvantaged children, there has also been a substantial movement to identify and provide educational opportunities to young handicapped children. As these opportunities for children and their families have increased, attention has gradually begun to be directed toward groups of children who, due to their relatively small numbers and particular circumstances, have not fully benefited from the availability of such programs and services.

Among the young children whose special learning needs have only recently begun to receive serious attention are American Indian and Alaska Native handicapped children. Based on sheer numbers, Indian* as well as handicapped children are minority groups. However, within each of these populations, the young Indian handicapped child is an even smaller and more vulnerable minority. Also, a disproportionate number of these children are poor. In essence, it is the combination of handicapping, cultural and socioeconomic influences that makes service delivery for young Indian handicapped children such a complex and challenging matter. Many of these children have varied educational needs that encompass elements of early childhood education, special education and Indian education.

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*NOTE: We use the term Indian to denote persons of both American Indian and Alaska Native backgrounds.

In order to provide the reader with a brief overview of early childhood special education services for Indian handicapped children, this chapter traces the development and current status of such programs and discusses some of the special considerations that are central to the planning and development of special programs and services for young Indian children with unique learning needs.

EDUCATIONAL NEEDS OF YOUNG CHILDREN

This section briefly discusses the need for early childhood and special education programs and relates such programs to Indian education.

Early Childhood Education

National support for early childhood programs in the form of kindergarten and nursery schools as supplements to the home can be found as early as 1950 (Reeves, Peniska and Heemstra, 1978). Since that time, numerous individuals have emphasized the need to provide programs and services for young economically disadvantaged children. In discussing the importance of appropriate early intervention for young disadvantaged children, Bender and Bender (1979) state:

> The high risk concept and accompanying theories have led to an increasing awareness of the need for early identification, especially as one reviews the developmental or physical problems that may occur early in the child's normal development and maturation process (pp.10-11).

It was, however, the enactment of the Economic Opportunity Act of 1964 that marked the beginning of a new era in programs for young children and their families. This far-reaching social legislation included Project Head Start, a comprehensive child development program designed to meet the needs of low-income and minority young children and their families within the community setting. In a recent report to the United States Congress, the U.S. General Accounting Office (1979) concluded after completing a review of these programs that:

> ... early childhood and family development programs for low-income families are needed; they can result in reduced health, social and educational problems in young children that are expensive and difficult to overcome in later years (p. i).

Other studies and reports have also pointed to the effectiveness of early childhood education programs for low-income children and their families. A study by the Consortium for Longitudinal Studies to the Education Commission of the States (1979) reported on the long-term effects of several early intervention programs. The data from this study revealed that early education programs for low-income children had lasting effects in areas such as reduced retention, increased mathematic achievement and test scores; and changes in attitudes and values of children and parents.

While many Indian tribes including Alaska Native corporations and villages are eligible to receive certain kinds of services through the federal government as a result of treaties, federal legislation, court decisions and executive orders, a large percentage of the Indian population continues to be disadvantaged as measured by economic, health, educational, and social standards. For example, according to a recent U.S. Department of Health, Education and Welfare (1979) report on the history of federal responsibility to the American Indian, the average income for Indians is substantially less than the national average, unemployment among Indians is more than ten times the national average, and the life expectancy for Indians is twenty years less than for other Americans. It was further reported that achievement levels for Indian students are two to three years below those of white students, dropout rates for Indian students are substantially above the national average in both public and federal schools, and only a small percentage of the Indian children in elementary school have Indian teachers or principals.

Concerning early childhood education programs and services for Indian children, the Bank Street College of Education (1976) report on young Native Americans and their families cited the following major reasons in support of the need for early childhood programs for young Indian children and their families:

- Unavailability of adequate health care for children.
- Inadequate prenatal care for mothers.
- Nutritional deficiencies.
- Lack of consistent nurturance and stimulation due to such factors as unemployment, alcoholism, transitional status of Indian cultures, etc.
- Culture and language differences.
- Unfamiliarity with existing educational systems.
- Lack of family resources to ensure success in the community and educational systems.

In addition to emphasizing the critical need for programs for children from birth to five and their families, other recommendations included the development of comprehensive programs and tribal involvement in the planning and administration of early childhood education programs.

Early Childhood Special Education

Based on a review of early intervention and longitudinal studies, Kirk (1977) proposed that the functioning of handicapped children can be improved if intervention is started at an early age. Perhaps the most succinct delineation of the need for early intervention is provided by Hayden and McGuiness (1977) who contend that early intervention is critical for young handicapped children for the following reasons:

- Early experience does have an influence, and that influence affects all areas of functioning.

- Research has shown that there may be critical periods for the development of certain skills, and that most of these periods may occur during the first three years of life.
- Failure to provide a stimulating early environment leads not only to a continuation of the developmental status quo, but to actual atrophy of sensory abilities and to developmental regression.
- All systems of an organism are interrelated in a dynamic way; failure to remediate one handicap may multiply its effects in other developmental areas, and may produce other handicaps (particularly social and emotional ones) that are secondary to the initial insult.
- With a delay in remediating an intellectual or cognitive handicap, there is a cumulative achievement decrement even within a single area of functioning, apart from the danger of secondary emotional or social handicaps; that is, the condition is progressive -- the child's developmental status inevitably becomes worse with respect to other children as he grows older.
- Early intervention has been shown to help; it can work to reduce the effects of a handicapping condition, and can do so more surely and rapidly than later intervention.
- The cost-benefit ratio of early intervention usually makes it more economical than later intervention.
- Parents need support during the early weeks and months after the birth of a child, before patterns of parenting become established.
- Parents need models of good parenting behavior with a handicapped child, and specific instructions for working with the child (pp 153-154).

In short, the earlier a handicapped child obtains stimulating, developmentally and culturally appropriate experiences, the greater his or her chance of participating in the larger community. This fact was underscored in the Bank Street College of Education (1976) study and was reflected in the recommendation that special education programs for the handicapped be an integral part of all educational programs serving young Indian children and that these services be coordinated with required medical and psychological services as well as with parent training.

EARLY CHILDHOOD EDUCATION, SPECIAL EDUCATION, AND INDIAN EDUCATION PROGRAMS

Recognition of the benefits of early intervention has led to increasing support of early childhood programs by federal as well as many state and tribal governments. This subsection reviews the role of several key federal agencies in supporting and furthering early education opportunities in special education, Indian education or both.

Administration for Children, Youth and Families

The agency is within the U.S. Department of Health and Human Services. It administers the Head Start program which is presently the most extensive and comprehensive national program making early childhood education services available to young Indian children. The Indian and Migrant Programs Division (IMPD), created to foster and strengthen Indian and migrant participation in Head Start, provides financial assistance directly to Indian tribes and Alaska Native entities to support programs in Indian communities. During the 1979 fiscal year, the IMPD expanded its services to young Indian children through a thirty-three percent increase in the number of Indian grantees. Ninety-three Indian grantees were serving 12,196 children between three years of age and the age of compulsory school attendance in twenty-two states during the 1979-80 school year.

In general, Head Start Program Performance Standards (1978) emphasize that a child can benefit most if a comprehensive, interdisciplinary program to foster development and remedy problems includes the child's family as well as the community. Consistent with this philosophy, local Head Start programs stress local planning and control, staffing flexibility to allow for utilization of paraprofessionals from the local community, parental involvement, training programs for staff development and adaptation of standard early childhood education curricula and approaches (Reeves, Peniska, and Heemstra, 1978).

Since 1976, Head Start has been mandated by the Head Start Economic Opportunity and Community Partnership Act of 1974, P.L. 93-644, to make available to handicapped children at least ten percent of the total program enrollment opportunities in each state. The most recent Department of Health, Education, and Welfare (1979) report on the status of handicapped children in Head Start programs indicated that for this past fiscal year, 9.6 percent of the children served by Indian grantees were professionally diagnosed as handicapped.

Bureau of Indian Affairs

The Office of Indian Education Programs within the Bureau of Indian Affairs (BIA), U.S. Department of the Interior, administers day and boarding elementary and secondary school programs in seventeen different states for approximately 45,000 Indian students. In terms of early childhood education programs, BIA involvement has traditionally focused on kindergarten classes at selected elementary schools. The approved BIA Fiscal Year 1979 Annual Program Plan required under P.L. 94-142, The Education for All Handicapped Children Act of 1975, provides a brief overview of Bureau services to young Indian children, including the handicapped:

> ...(the) current practice of BIA schools is to serve students age 6-18.... There are some preschool and kindergarten programs. Of the 208 school programs, Bureau operated and Bureau contracted, 105 of them have kindergarten programs servicing children age five and two preschool programs servicing children ages three to five.
>
> The BIA Manual will be amended to include children served by these early childhood programs in the regular service population of the Bureau of Indian Affairs education systems. Handicapped children, ages three to five, will be served as they enter Bureau school systems....

For fiscal year 1979, the Bureau reported that 116 handicapped children ages three to five were provided special education services (The Council for Exceptional Children, 1980). Eighty-three percent of these students were identified as speech impaired, mentally retarded or learning disabled.

While BIA support for early childhood education has been very limited, the Bureau is currently considering the appropriate weight factors needed to include prekindergarten programs in the new Indian School Equalization Formula for fiscal year 1982. In addition, the Bureau, for the first time, has officially included early childhood education within the educational opportunities to be available to young Indian children receiving or eligible to receive school services from the Bureau (Department of the Interior, 1979).

Office of Special Education

The Office of Special Education (formerly The Bureau of Education for the Handicapped), Office of Special Education and Rehabilitative Services within the newly created U.S. Education Department administers discretionary programs and state grant programs to assist states and their localities, institutions of higher education and organizations that educate handicapped children and youth. Foremost among the discretionary programs is the Handicapped Children's Early Education Program (HCEEP) which was established in 1969 under Part C of the Education of the Handicapped Act, P.L. 92-230. Since its inception, numerous exemplary projects have been developed to demonstrate how services to young handicapped children might best be delivered. During this time, the HCEEP program has supported five projects that have had target populations of young Indian handicapped children. Four of the five were administered by local tribal governments and the fifth was developed and operated by a university. The types of disabilities served covered the spectrum of handicapping conditions, with the highest proportion being the speech/language impaired.

In addition to the HCEEP program, the Office of Special Education also makes resources available under the auspices of P.L. 94-142. This landmark law provides states, including the BIA, with funds based on an approved state plan to be used for the education of handicapped children. There is also a "preschool incentive" provision which provides additional funds to states and the BIA to encourage the development of statewide early childhood special education programs and services. Unfortunately, data collection practices have in most instances not yet yielded information on the number of Indian handicapped children served by the states under the basic state grant program or the preschool incentive grant program.

Office of Indian Education

The Office of Indian Education (OIE) within the Office of Elementary and Secondary Education of the U.S. Education Department provides financial assistance to local education agencies, Indian tribes and Indian organizations to meet the special educational needs of Indian children. Under Part B of the Act, there are provisions for the development and establishment of education service projects specifically designed to improve educational opportunities for Indian children of preschool, elementary and secondary school age. Projects must be designed to improve educational services that are not available in sufficient quantity or quality. Among the kinds of services that can be supported under this authority are preschool programs, special education programs for the handicapped and bilingual and bicultural education programs.

During the 1975 fiscal year, the OIE provided funding for twenty-nine early childhood education projects which served 1,672 children. During this same period, OIE also supported two projects which served 425 handicapped students (Office of Indian Education, 1976).

SPECIAL PROGRAM CONSIDERATIONS

As Indian tribes, Alaska Native regional corporations and villages, and public and BIA schools begin to plan and provide services to young Indian handicapped children, it will be necessary to consider and integrate many of the practices of early childhood education, special education and Indian education. In addition, language and cultural diversity, unique and multiple administrative arrangements and the rural and sometimes isolated or remote locations of many Indian communities require special consideration.

Some of the program areas requiring the particular attention of those providing or seeking to provide services to young Indian handicapped children include tribal involvement, culture, personnel, provision of related services, student eligibility and jurisdiction, child evaluation and facilities. We might add that these areas are discussed in greater detail in subsequent chapters.

Tribal Involvement

While several tribal governments with tribal education divisions have encouraged other groups within the community to develop programs for handicapped children, generally more involvement has occurred in early childhood education programs as evidenced by the more than ninety Indian Head Start grantees. A major part of planning and developing any education program, in terms of Indian self-determination, is involving the tribal government, its representatives, and the local Indian community. Depending on location and the particular agency sponsoring and/or operating the program (i.e., tribal agency; Indian organization; or public, BIA, tribal or Indian-controlled, or cooperative school), tribal participation can take a number of different forms. Some of the kinds of responsibilities and activities tribes have undertaken with respect to early childhood special education programs include:

- Enactment of resolutions of support.
- Provision of some level of financial support.
- Management of the program.
- Interagency cooperation to utilize resources and share other educational, health and human services.
- Dissemination of program information at tribal, intertribal, regional and national meetings and conferences.

Culture

A major consideration for individuals planning and developing services for young Indian handicapped children is the culture of the children participating in the program. In general, culture refers to habitual patterns of behavior that are characteristic of a group of people which are transmitted from one generation to the next (Kroeber and Kluckhohm, 1952). More specifically, Aragon (1974), after reviewing sociological and anthropological concepts, proposed the following elements for viewing cultural diversity among groups:

- Common patterns of communication, sound system or language which are unique to that group.
- Common basic diet and method of preparing food.
- Similar kinds of dress or common costuming.
- Common socialization patterns.
- Common set of values and beliefs.

Pepper (1976) has contrasted some of the values held by Indian people as a whole with those of people in the dominant society. Sando (1974) has demonstrated how the Indian concept of time can affect the school performance of Indian children as a group -- citing problems with attendance, scores on timed tests or assignments, attention and the willingness to plan ahead and delay gratification.

It is also important to be or become knowledgeable about and sensitive to the history, culture and values of the Indian children and families served by the program. The Indian community is a rich cultural resource; whatever means are used to include its heritage in the program should be ongoing and should allow for a thoughtful selection of the cultural elements to be emphasized. A word of caution is also in order since, depending on the particular Indian tribe, there are certain aspects of Indian culture that are viewed as a prerogative of the home and are not appropriate for the classroom.

In terms of the program, cultural differences need to be articulated as appropriate and their effects considered throughout the identification, evaluation and placement process (Ramirez, Pages and Hockenberry, 1979), in curriculum development, and in instructional planning activities (Pepper, 1976; Almanza and Mosley, 1980). Some of the specific ways cultural and language considerations must be addressed are:

- Child identification activities based upon identified cultural and language differences.
- Determination of the child's dominant language and English proficiency prior to selecting and conducting individual evaluations.
- Native language interpreters.
- Involvement and communication with Indian parents, guardians, and, when they are acting in the place of a parent, members of the extended family.
- Development and introduction of appropriate culturally relevant materials and resources into the curriculum.
- Utilization of elders and other resource people from the Indian community in program activities.
- Inservice training on topics such as traditional and contemporary beliefs and attitudes about the handicapped, tribal culture and language, characteristics of Indian students, relevant curricula for Indian students, etc.

Personnel

A continual obstacle to full and appropriate services for Indian students of preschool, elementary and secondary school age is the recruitment and retention of qualified staff (Ramirez and Tippeconnic, 1979). In many instances, these problems are compounded by the geographic and climatic demands of rural, remote and isolated areas as well as limited housing facilities. At the same time, much has been written about the desirability and potential benefits of having educators of the same racial and cultural background teach and direct programs for culturally diverse children. As evidenced by our national policy of Indian self-determination and Indian preference in selected employment and training, this is also a primary consideration in the development and improvement of educational programs for Indian students.

Unfortunately, there is presently an acute shortage of Indian and Alaska Native professionals in early childhood education, special education and related service areas. While intensive recruitment that includes prominent state and BIA agencies as well as institutions of higher education with Indian training programs might yield promising qualified candidates, circumstances in many cases will necessitate the hiring of non-Indian personnel. When this is the case, inservice training must be provided to develop the attitudes and skills necessary to work with Indian children and families.

Provision and Coordination of Related Services

The multidisciplinary needs of many handicapped children mean that related services such as diagnosis, audiology, speech pathology, physical therapy, occupational therapy, counseling, health and social services, and transportation must be available. These services may or may not be provided through the program. In many instances they are available through other federal, state, tribal and local agencies or private practitioners on either a cooperative or contract basis. Some of the health and social service agencies that have collaborated with local educational agencies serving Indian reservations and Alaska Native villages include BIA, Social Services, Indian Health Services, State Department of Mental Health/Mental Retardation, Youth Services, tribal health and human services agencies and institutions of higher education including Indian community colleges (Ramirez, Pages and Hockenberry, 1979). Many related services are also available through private practitioners on a contractual basis.

Problems are sometimes encountered when programs try to assume total responsiblity for providing all the services necessary to operate a comprehensive special education program. Although this may appear to be the easiest approach, it is oftentimes not cost effective or practical, particularly when great distances and low-incidence exceptionalities are involved. For these reasons, program directors need to become aware of the various services available through other agencies and take the necessary time to coordinate the availability of such services. In this regard, cooperative agreements, formal and informal, can greatly facilitate comprehensive service delivery.

Student Eligibility and Jurisdiction

Questions about student eligibility and educational jurisdiction often arise when more than one educational agency is involved in the delivery of services to young children within the same geographic area. For example, depending upon the local setting and state, BIA, Head Start or tribal program eligibility requirements, young Indian handicapped children may be eligible to receive services from one or more of the following school programs:

- Head Start which has a ten percent mandate to serve handicapped children between three years of age and the age of compulsory school attendance who meet Head Start income guidelines.

- Local public school districts in states with mandatory and/or permissive legislation regarding early childhood education for the handicapped.

- BIA schools and tribal schools under contract with BIA which permits permissive education of children five years or younger, but in practice presently serves children ages six years and older.

- Early childhood special education demonstration/discretionary projects operated by tribes, Indian organizations or local schools which have variable age and exceptionality requirements depending upon stated goals and objectives.

The problem of educational responsibility for young Indian handicapped children is further complicated by the variation in state eligibility requirements. According to Cohen, Semmes and Guralnick (1979), only thirteen states are currently mandated to provide special education programs for handicapped children three through five years of age. In other states, the legislation is permissive or absent for some handicapping conditions while mandatory for others.

While there are widespread differences in state early childhood special education provisions, Section 504 of the Rehabilitation Act of 1973, P.L. 93-112, prohibits discrimination against handicapped persons in programs receiving federal financial assistance from the Department of Health, Education and Welfare. This means that if a state or local education agency makes kindergarten services available to nonhandicapped children, it must offer those services to handicapped children as well. Similarly, a day care program receiving federal financial support cannot exclude children on the basis of their handicap. Failure to comply with the 504 requirements could result in a loss of federal funds.

The problem of which educational agency is to assume primary responsibility for the identification, evaluation, placement and provision of services to young Indian handicapped children has yet to be resolved in many areas; however, in others much progress has been achieved. For example, four states have signed agreements recognizing Head Start as an acceptable placement for young handicapped children (Cohen, Semmes and Guralnick, 1979). In other instances, cooperative agreements between educational agencies have been developed specifying respective responsibilities. Such arrangements lessen the likelihood that young handicapped children will "slip between service delivery cracks" and can provide a basis for providing comprehensive services.

Child Evaluation

Over the past several years, considerable attention has been directed toward the evaluation practices and procedures employed by schools and other educational programs. In part, this has largely stemmed from instances of over-representation of minority, culturally-diverse children in classes for the handicapped. In the absence of compelling evidence to the contrary, advocates and others have repeatedly challenged the disproportionate representation of Black, Hispanic and Indian children in special education programs (Arreola v. Board of Education, 1968; Covarrubias v. San Diego Unified School District, 1971; Diana v. State Board of Education, 1973; and Larry P. v. Riles, 1972). In this regard, it is alleged that the imbalance in special education is a result of racial and cultural bias in school procedures and practices.

While individuals developing programs must be sensitive to the concerns of parents of culturally-diverse children regarding evaluation, evaluation should not be considered an end in itself but a component of a process that also involves intervention. Both P.L. 94-142 and the regulations for implementing Section 504 contain similar provisions which require nondiscriminatory evaluation. Foremost among the stipulations are that evaluation be multidisciplinary and tests and evaluation materials be administered in the child's native language or other mode of communication.

While adherence to these and other provisions will improve the evaluation of culturally different children, it is also important that those involved in assessments become familiar with and consider cultural behaviors in the interpretation of assessment data (Bernal, 1977). Great care must be taken to ensure that qualified professionals and appropriate instruments and methodologies are used in evaluating young Indian children.

Facilities

Another issue that repeatedly comes to the forefront of discussions concerning developing educational programs and services for Indian children is facilities. Most Indian and Alaska Native communities have very limited or no resources available for expanding existing facilities for additional programs. In most instances, existing educational buildings are the result of some agency, such as BIA, having established residential or day schools in the community and their use is often preempted by the needs of those programs.

Despite this difficulty, program personnel operating early childhood programs have demonstrated great resourcefulness in establishing early education centers in churches, basements of public buildings, portable classrooms or trailers, abandoned buildings/homes as well as other temporary facilities. Investing in the cost of remodeling or repairing older structures to make them meet local and/or state building code requirements as well as accessibility standards is oftentimes the most reasonable immediate alternative to constructing a new building or purchasing a less permanent structure.

Although the acquisition and maintenance of facilities is a potential barrier to providing services to young children, it is not an insurmountable one. After the program has been established within the community, more desirable facilities can often be made available or even constructed. Moreover, access to resources for maintenance and facility modification can sometimes be coordinated with tribal and other local agencies.

SUMMARY

This chapter has provided the reader with a general overview of early childhood special education for young Indian children. As indicated by the large number of Indian tribes and Alaska Native entities presently involved in the education of preschool children, a basis already exists upon which to build and expand services to handicapped children within many Indian communities. In this regard, Indian tribes and organizations as well as local education agencies have utilized financial assistance from several federal agencies charged with early childhood education, special education, and Indian education responsibilities.

This chapter also identified some of the major variables that merit special attention during the planning and development of early childhood special education programs for young Indian children. These as well as other distinguishing characteristics of service delivery in Indian communities are addressed throughout subsequent chapters. In calling attention to these considerations, the reader is reminded that programs for young Indian handicapped children are not the sole province of any one discipline: services should reflect the childrens' ages, exceptionalities and distinctive cultures.

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CHAPTER 2

Strategies for Screening, Assessment and Diagnosis

by *William W. Swan and Jacqueline L. Walker*

INTRODUCTION

In order to plan services for handicapped preschoolers and their families, children who may be eligible to receive special education and related services must be identified. Then those services which will best assist them in reaching their full potential can be determined.

With American Indian and Alaska Native children, the identification process must be carefully planned to avoid procedures and tests which do not account for the unique linguistic and cultural characteristics of this group.

In this chapter, we will review the scope of each of the evaluation processes (screening, diagnosis, assessment) and the requirements for each that are specified in federal legislation. We will then offer principles which will be useful in developing child evaluation programs which satisfy the intent and the letter of the law. Sample systems for screening and diagnosing are then presented, and the chapter concludes with a review of the issues of specific concern when evaluating American Indian or Alaska Native handicapped children.

DEFINITIONS AND REQUIREMENTS

Definitions

Identification consists of three sequential activities: screening, diagnosis, and assessment. Screening is:

> a procedure to separate those children from the population being screened who appear to need special educational services to help them achieve their highest possible functioning level (Lillie in Cross and Goin, 1977, p. 17).

Diagnosis is:

> a process designed (1) to confirm or disconfirm the existence of a problem serious enough to require remediation, in those children identified in a screening effort and (2) to clarify the nature of the problem... (Cross in Cross and Goin, 1977, p. 25).

And assessment is:

> The systematic process of (1) collecting information both on a child's level of functioning in specific areas of development and on his learning characteristics and (2) carefully interpreting the information ... to develop a comprehensive and specific educational plan which provides the information that is necessary in planning a day-to-day program for the child (Harbin in Cross and Goin, p. 35).

Screening is conducted with large groups of children to determine those who may have some problems. Diagnosis is used to determine which children do (and which ones don't) have problems and to clarify the nature of the problem. Assessment is provided to those children who need special programs to assist them in reaching their potential. Screening is generally cheaper than diagnosis or assessment; this is true because (1) it takes less time, and (2) does not require persons with as much training as the other two activities. Screening and diagnosis are useful in determining which children don't have problems as well as those who do. Finally, all three activities should be used to identify strengths of children as well as weaknesses.

Requirements

P.L. 94-142, the Education for All Handicapped Children Act, requires screening, diagnostic and assessment activities which include: "child find," protection in evaluation, individualized educational programs (IEPs), least restrictive environment, and confidentiality/due process/complaint procedures.[1] Child identification (Child Find) primarily concerns screening. Protection in evaluation and confidentiality/due process/ complaint procedures relate to screening, diagnosis and assessment. IEP and least restrictive environment relate primarily to diagnosis and assessment.

Child Identification. P.L. 94-142 Regulations (121a.220; 121a.128) require that the school district conduct efforts to identify (screen), locate, and evaluate (diagnose) all handicapped children ages birth through twenty-one years. While the law does not require that children from birth to three years be served, handicapped children within this range must be identified, located, and evaluated. All relevant agencies must be involved on an ongoing basis in conducting child find efforts, including in-school screening, for the age range of birth to twenty-one years.

Protection in Evaluation. This requirement (P.L. 94-142 Regulations 121a.530-534; 121a.133) includes the following provisions:

1. Parental consent is obtained prior to a child's initial evaluation (diagnosis).
2. Procedures and tests may not be racially or culturally discriminatory.
3. Tests are administered in the child's native language.
4. Valid tests are used by trained personnel using standard procedures.
5. Tests reflect the child's aptitude and achievement.
6. Tests address areas of specific educational need.

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[1] It is important to note that the law requires all children ages three to twenty-one years to be served by September 1980, except for the three- to five-year-old group and the eighteen to twenty-one year old group; all children in these age groups must be served except in those states in which provision of such services is in conflict with state law, court order, or state practice.

7. Assessments (diagnoses) are made in all areas of suspected disability.
8. Multiple tests are used to determine a child's eligibility for special education and related services and his/her educational program needs.
9. A multidisciplinary team conducts evaluation.
10. Information from a variety of sources is documented and considered in making placement decisions.

Individualized Educational Program. The IEP is mandated by P.L. 94-142 (Regulations: 121a.130, 121a.340-348). It must contain a statement of the child's present performance level, the goals and objectives, the special education and related services to be provided, the extent to which the child will participate in regular education programs, dates of initiation and duration of services, and objective evaluation criteria and procedures. Those who must participate in its development are the parents, who must be notified in a timely manner of the IEP meeting which will be held at a time and place convenient for them and other participants; teachers; a school district representative; evaluation (diagnostic) personnel; and other persons at the discretion of the parent or the agency.

The IEP must be completed within thirty calendar days of the evaluation for newly diagnosed children. An annual review or revision of the IEP is required. Parents can request a formal hearing if they are dissatisfied with an IEP or its implementation. If a child is placed in a private school, an IEP is developed with the private school representative before placement is made. The public schools are responsible for the implementation of the IEP in the private school.

Least Restrictive Environment. Least restrictive environment is a required part of all IEP's (Regulations 121a.132, 121a.550-556). Each handicapped child must participate to the extent appropriate with nonhandicapped children in academic settings. Alternatives for placement must be considered as follows: regular classes, special classes, special schools, home instruction, hospitals and institutions and supplementary services provided in conjunction with regular classroom instruction (see pp. 48-49). Placements are determined annually, based on the IEP, and are as close as possible to the child's home and to the school the child would attend if he or she were not handicapped. This requirement must be adhered to in both public and private institutions.

Confidentiality/Due Process/Complaint Procedure. Confidentiality is required by the law (Regulations 121a.129, and 121a.560-575). Parents and children have rights of access to records, to lists of types and locations of information. And they have the right to have records amended, to institute hearings, to give their consent to release information, and to order destruction of records. Requests for records by parents must be responded to within forty-five days. In a hearing, parents also have the following rights: to counsel, to enter evidence, including expert testimony, to cross-examine, to hear transcripts, to obtain a copy of findings, to appeal, and to bring civil action. Prior notice and parental consent for initial evaluation (diagnosis) and all placement changes must be provided in a reasonable and timely manner, and there must be agreement between the parents and the public agency about the child's status during due process proceedings. The public agencies may exercise the same rights in responding to a child's needs. In the case of disagreement between the parties, there is provision for a formal complaint procedure (Regulation 121a.602) which requires that a particular person be responsible for implementing the system and responding to complaints within specified periods of time.

PRINCIPLES

The measurement principles outlined below are based on these definitions and requirements. One principle is of particular importance: Before implementing screening, diagnosis and assessment activities, the child's native language must be determined. This is especially important with American Indian and Alaska Native children. Three points need to be considered in making this determination:

1) language dominance, which may range from monolingual, non-English speaking to monolingual, English speaking. Along the continuum are points that fall between the two extremes:
    a) monolingual, non-English speaking but with some competencies in English
    b) parallel bilingual
    c) English as dominant language, with competencies in another language
    d) nonstandard English dialect
2) language competency, which provides information regarding the competency levels in either English or another language, or in more than one language.
3) interference, which refers to the degree of interference the "other" language causes in the educational/learning process.

This principle is absolutely critical in obtaining accurate and fair results from screening, diagnosis and assessment.

Screening Principles

1. Parental permission must be obtained prior to screening a child. The purpose and procedures of screening must be explained to the parents/guardians of a child and their permission obtained

before the child may be screened.

2. Screening should be as accurate as possible. Only those children who really need help should be identified. It is generally better to slightly overestimate than underestimate the number of children needing help since those children identified will receive more thorough testing in diagnosis. Reliable and valid screening tests are the best way to get accurate results.
3. The measures used in screening should be culturally nondiscriminatory. The screening tests should be appropriate for the language and the culture of the children being screened.
4. The screening should be comprehensive. All areas should be considered including cognition, speech/language, hearing, vision, physical health, fine and gross motor development, and self-help and socialization skills.
5. The screening should not be repeated. For instance, if one group screens a child for vision, that same child should not be rescreened for vision. This principle includes a requirement for coordination and cooperation between agencies and other groups interested in the welfare of the child and his/her family.
6. The screening should be coordinated with diagnostic efforts. Children who are identified in screening should be diagnosed as soon as possible to limit child and parent anxiety. Screening results must be shared with parents as soon as possible.
7. Screening should be as inexpensive as possible. Adequately trained volunteers and special interest groups can often implement screening procedures more effectively than highly trained persons because often they provide a more relaxed atmosphere in which the child can respond.

Screening can be implemented in a variety of settings. It is generally best to screen in some central gathering point, perhaps in conjunction with some general event in which children would normally participate. Planning for the activity should include representatives of all groups which will participate in the screening process. Training of volunteers and others should be included in planning the screening effort.

Diagnostic Principles

Diagnosis should provide for an indepth review of a child referred during screening. It requires highly trained professionals (psychiatrist, urologist, speech pathologist, and so on) to examine particular areas of a child's functioning. There are several principles which should be considered in designing diagnostic procedures.

1. Parental permission must be obtained in order for a child to be diagnosed. After parents are informed of the screening results, the purpose and procedures of the diagnostic process must be explained before the child may be diagnosed.
2. Diagnostic testing should be comprehensive and coordinated to require as few sessions as possible. A child's functioning in all areas, especially those identified in screening as potential problems, should be diagnosed. This requires organizing all relevant professions so that the child and family participate in the minimum number of testing procedures necessary. Furthermore, strengths as well as weaknesses should be identified for each child.
3. Diagnostic procedures must include obtaining an indepth history of the child's development from the parent or guardian and observation of the child in real life settings. Oftentimes,

preschool children do not perform well in unique or different settings. Because an accurate picture of a child's functioning is desired, a full developmental/medical history must be taken before diagnosis begins.

4. Culturally-relevant tests must be used for diagnostic efforts. An accurate perception of the child's abilities depends on the use of nondiscriminatory procedures.

5. The diagnosis must yield, after an indepth analysis, a synthesis statement of confirmants or disconfirmants as well as a statement of the nature of the problem. Unless the team provides a comprehensive, cohesive statement of the result, the efforts to meet the child's needs will not progress.

6. The diagnostic effort must be coordinated with assessment procedures so the content of a program to meet the child's needs can be developed. The diagnostic process must result in a group meeting, including parent participation, either to develop an individualized educational program (IEP) to meet the child's needs or to communicate with the parents that there is no need for special services.

For a number of children, the diagnostic procedure will disconfirm the presence of a problem. While one hopes this number is small because of accurate screening procedures, it is as important to disconfirm as it is to confirm potential problem areas.

Assessment Principles

Assessment procedures should be used periodically to update the individualized educational program (IEP) for the child. There are several principles which should be considered in devising assessment methods:

1. The assessment should focus on those objectives/goals which

are contained in the child's IEP. One of the major purposes of assessment is to provide a means of planning for a child's instruction on a day-to-day basis. Unless the assessment is related to these objectives/goals, the information gathered may not be of direct use.

2. The assessment should consider behavior in the home as well as in the service delivery setting. The child's behavior in settings outside the school (or institution) are important in determining if the child is generalizing skills being learned. For this reason, it is extremely important (and required) for the child's parents to be involved in the assessment effort.
3. Assessments should be completed periodically throughout a service year. Assessment should not be a "one-shot effort," but should be completed at planned times.
4. Assessment should not depend on standardized measures alone. Information should be gathered in a variety of ways and from instruments which are reliable and valid for the situations in which they are used.
5. The results of an assessment should be summarized in a format which has meaning for those who will use it. Unless those who need to use the assessment data can understand it, the information is not being used for the benefit of the child.

SYSTEMS FOR SCREENING, DIAGNOSIS, AND ASSESSMENT

Several systems provide for the special education of young handicapped American Indian and Alaska Native children. They include Head Start, Bureau of Indian Affairs early education programs, Office of Special

Education demonstration projects, and Office of Indian Education supported programs. There are similarities among the systems in the activities that are undertaken in screening, diagnosis and assessment.

Figure 1 provides one example of a system for screening based on the principles on pp. 26-27. Its purpose is to identify children who may be handicapped and in need of special education/related services. It includes specific activities identifying personnel responsible and other resources which might be considered for each activity. Provisions are made for a multidisciplinary team, for screening a variety of areas, and for relating screening results to diagnostic efforts. Adaptations of this example would be necessary in order to use it in a given situation. However, it does provide for the coordinated use of personnel often available in the screening of American Indian and Alaska Native children.

Figure 2 provides an overview by potential handicapping conditions of the professionals who should be involved in the diagnosis of children. Along the left side, the potential areas of handicapping conditions are listed to provide a framework to assure that all areas are considered. The professionals to be used in the diagnostic system are identified along with the credentials that are generally required for professional certification. Related qualifications, for professionals working with American Indian and Alaska Native children, are also provided.

One application of this overview is the diagnosis of a potentially mentally retarded child who is observed to be functioning at very low levels in motor and speech/language domains. The professionals that might be involved in the diagnostic processes would likely include an educator, a psychologist, speech pathologist, and physical therapist. A series of activities, personnel responsible, and other resources,

Figure 1

An Example of One System for Screening

Activity	Personnel Responsible	Other Resources
1.0 Identify all children to be involved in screening activities, based on existing enrollment and recruitment activities.	1.10 Individual designated as responsible for screening activities may often be: 1.11 Health coordinator 1.12 Handicap coordinator 1.13 Enrollment coordinator 1.14 Classroom teacher	1.20 Tribal education or related program 1.21 BIA social service 1.22 BIA education 1.23 Indian Health Service (IHS) personnel
2.0 Conduct screenings in the following areas:	2.10 Individual designated as responsible for screening activities will coordinate. Actual screening may be conducted by any of the following persons, individually or cooperatively.	
a. Development (cognition, fine and gross motor, self-help and socialization.)	a. 1) Classroom teacher 2) Health coordinator 3) Education Coordinator 4) Handicap coordinator 5) Parent	a. IHS personnel
b. Vision	b. Same as "a" above	b. 1) IHS personnel 2) Optometrist
c. Hearing	c. Program personnel trained to conduct hearing screening using pure tone or impedance audiometers	c. 1) IHS personnel 2) Audiologist
d. Medical	d. not normally done at program level	d. 1) IHS personnel 2) Private physician
e. Speech/language	e. 1) Classroom teacher 2) Education coordinator 3) Handicap coordinator 4) Health coordinator 5) Speech pathologist	e. 1) Private speech pathologist
3.0 Review screening results.	3.10 Team effort, may involve any of the following: 3.11 Classroom teacher 3.12 Speech pathologist 3.13 Education coordinator 3.14 Health coordinator 3.15 Handicap coordinator 3.16 Parent	3.20 Outside individuals or resource persons as deemed appropriate. Would normally include those involved in screening activities.
4.0 Schedule children not passing screening for: a. rescreening OR b. referral for evaluation	4.10 Individual designated as responsible for screening and follow-up activities is responsible. Often done as team effort involving individuals listed above	4.20 None

FIGURE 2

One Overview of a Diagnostic System

Showing Handicapping Condition and Kind of Professional Involvement

HANDICAPPING CONDITIONS	INTERVENTION ACTIVITY/PRIMARY PARTICIPANT: Parent Conference* / Parents	Educational / Teacher	Psychological / Psychologist	Audiological / Audiologist	Speech/Language / Speech Pathologist	Visual / Opthalmologist	Occupational Therapy / Occupational Therapist	Physical Therapy / Physical Therapist	Medical Exam / Physician	Other as Necessary	PROFESSIONAL CREDENTIALS REQUIRED	RELATED QUALI-FICATIONS
Mentally Retarded	●	●	●	●		●	●	●			Certification by state in which services are being provided.	1) Preferred training and/or experience specific to children ages 0 - 8. 2) Preferred training and/or experience specific to culturally different and/or linguistically different children, particularly American Indian or Native Alaskan.
Speech Impaired	●	●	●	●	●						Same as above	
Deaf/Hearing Impaired	●	●	●	●	●				●		Same as above	
Visually Handicapped/Blind	●	●	●			●			●		Licensed or certified by the state in which services are being provided. Should be noted that opthalmologists are physicians, while optometrists are not.	
Other Health Impaired	●	●	●						●		Licensed physicians	
Physically Handicapped	●	●	●				●	●	●		Certified by state in which services are being delivered.	
Seriously Emotionally Disturbed	●	●	●								Licensed by state in which services are being provided. Should be noted that psychiatrists are physicians while psychologists are not.	
Specific Learning Disabled	●	●	●								Licensed or certified by state in which services are being provided. Credentials should qualify individual to conduct evaluations of LD children.	
Multiply Handicapped	●	●	●	●	●	●		●	●		Licensed or certified by state in which services are being provided.	

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*Including general medical information.

similar to those in Figure 1, might be developed for an overall diagnostic system.

A system for assessment may be developed using the sample plan in Figure 1 and the sample overview in Figure 2. Assessment must also take into account the specifics in the IEP and the assessment principles.

There is no one screening, diagnosis, or assessment plan which can be used in all situations. The principles, along with the examples presented here, provide a base from which to develop and implement a plan to identify children needing special education/related services. Any existing system(s) already being used should be considered prior to implementing new systems.

ISSUES SPECIFIC TO PRESCHOOL AMERICAN INDIAN AND NATIVE ALASKAN CHILDREN

Language Considerations

One of the most pressing issues, one that is repeatedly mentioned as being critical, but also an obstacle to the screening, diagnostic and assessment process, is the consideration of native language when identifying handicapped children. Because of the diversity and uniqueness of the hundreds of American Indian and Alaskan Native cultures and languages and/or dialects, it is not an easy task to set standards for determining native language dominance or competencies. Most people agree that the language/dialectical factors tend to interfere with the screening, diagnosis and assessment processes. Questions are frequently raised as to the validity of screening, diagnostic and assessment results when all language factors have not been considered -- or if considered, still present problems. Problems might encompass such situations as follow:

1. Monolingual, native-language-speaking children with no trained professionals who speak the native language present a very basic communication problem when conducting screening, diagnosis, or assessment.
2. Interference of native language or dialect with learning and cognitive processes may become evident in testing results. An unknown variable may be: How much interference must be evident to possibly void a diagnostic confirmation?
3. Errors occur in both confirming and rejecting diagnoses. This is especially true with mildly impaired children who may have either native language or dialect competencies.
4. Language factors may lead to an overabundance of children identified as having one particular handicapping condition versus another, e.g., specific learning disability.
5. Given a monolingual, native-language-speaking child, selecting appropriate screening, diagnostic and assessment tools creates a problem. It is not practical to expect translated versions of standardized instruments, especially when there are limited populations on which to norm such instruments, and the number of potential translations is great.

Recommendations. There are several alternatives that might be suggested to minimize the impact of the language-related factors on the screening, diagnosis and assessment process.

One is the use of interpreters who have received training in testing procedures and testing instruments. They would work with trained professionals when necessary to interpret verbal instructions and child responses. This can be effective when trained professionals and program personnel work together to ensure that appropriate instruments and procedures are implemented in a manner that is consistent with unique language and cultural characteristics as well as P.L. 94-142.

Another alternative may be to train native language speakers to implement screening, diagnosis and assessment procedures directly. This alternative will require training time and other resources to develop a cadre of skilled, trained individuals, at either the preprofessional or professional level.

An important element that may help to minimize language-related problems is the awareness program personnel have of all the potential language-related factors that might come into play. Also needed is the capability to intervene with appropriate strategies as problems arise. Appropriate strategies may differ from community to community but will be based on a foundation of knowledge regarding the local culture; local language characteristics; background in basic language development theory; general testing procedures; screening, diagnostic and assessment instruments; and most of all, the principles involved in screening, diagnosis and assessment.

Use of Appropriate Instruments

The appropriateness of the existing screening, diagnostic/assessment instruments for use with this particular population is questionable. Several of the projects which serve handicapped American Indian and native Alaskan children have been involved in using standard assessment and diagnostic instruments, as well as developing and using informal instruments. As yet, however, no empirical evidence has been provided that gives insight into which specific instruments have proven to be discriminatory, or what alternatives exist.

Some of the more commonly used screening instruments include: The Denver Developmental Screening Test, Boyd Developmental Checklist, Comprehensive Information Profile (CIP), and the DIAL. Instruments/systems commonly used in assessment of this population in early childhood settings include the Learning Accomplishment Profile (LAP) and the Portage Checklist. Many programs have also developed and/or are using informal instruments in the assessment process.

Recommendations. Any instruments should be used with input from individuals who are knowledgeable about educational testing and measurement as well as the implications for culturally and linguistically different groups. Also, when programs consider developing or using informal instruments, thought should be given to the validity and reliability of those instruments. Programs must be certain that the instruments they use give them the information they want and will be consistent over time.

It is essential that instruments be intensively reviewed and that program planners and implementors be selective in identifying the instruments they will use in screening/diagnosing/assessing their children.

Qualified Diagnostic Professionals

There is a dearth of qualified professionals trained to screen, diagnose, and assess preschool handicapped children. This problem, intensified by the need for trained professionals who have experience or knowledge of American Indian or native Alaskan communities and children, becomes an obstacle to providing appropriate services to children in an effective and efficient manner.

Recommendation. In the identification and selection process to be used by program planners in choosing appropriate professionals for evaluation and diagnosis, great care has to be given to recruiting and using the services of trained professionals with the appropriate experience who will do an acceptable job of providing an accurate diagnosis. Some programs have actually provided training to competent professionals to orient them to the unique characteristics of the children they would serve. Also working with colleges and universities to develop and provide special education curricula for American Indian/Alaska Native persons can be an effective means of obtaining qualified professionals and paraprofessionals.

Diagnostic Process

Another issue centers around the diagnostic process itself and the methods used to determine if a child is handicapped. The law specifies that a multidisciplinary team approach be taken in order to provide for the diagnosis of "all areas related to the suspected disability." This approach is especially important to American Indian and native Alaskan children. Actual practice often excludes the use of more than one professional. That one person is usually the professional that certifies primary handicapping conditions. In early childhood settings this is typically due to lack of access to trained professionals as well as fiscal resources. If, however, an education setting is cooperating with a State Education Agency or the Bureau of Indian Affairs in the implementation of P.L. 94-142, the lack of fiscal resources or human resources cannot be used as an argument for noncompliance with the law.

Recommendation. A multidisciplinary approach should be used. Information obtained from parents and teachers, observations in the educational and community environment, and information obtained from other service pro-

Some of the more commonly used screening instruments include: The Denver Developmental Screening Test, Boyd Developmental Checklist, Comprehensive Information Profile (CIP), and the DIAL. Instruments/systems commonly used in assessment of this population in early childhood settings include the Learning Accomplishment Profile (LAP) and the Portage Checklist. Many programs have also developed and/or are using informal instruments in the assessment process.

Recommendations. Any instruments should be used with input from individuals who are knowledgeable about educational testing and measurement as well as the implications for culturally and linguistically different groups. Also, when programs consider developing or using informal instruments, thought should be given to the validity and reliability of those instruments. Programs must be certain that the instruments they use give them the information they want and will be consistent over time.

It is essential that instruments be intensively reviewed and that program planners and implementors be selective in identifying the instruments they will use in screening/diagnosing/assessing their children.

Qualified Diagnostic Professionals

There is a dearth of qualified professionals trained to screen, diagnose, and assess preschool handicapped children. This problem, intensified by the need for trained professionals who have experience or knowledge of American Indian or native Alaskan communities and children, becomes an obstacle to providing appropriate services to children in an effective and efficient manner.

Recommendation. In the identification and selection process to be used by program planners in choosing appropriate professionals for evaluation and diagnosis, great care has to be given to recruiting and using the services of trained professionals with the appropriate experience who will do an acceptable job of providing an accurate diagnosis. Some programs have actually provided training to competent professionals to orient them to the unique characteristics of the children they would serve. Also working with colleges and universities to develop and provide special education curricula for American Indian/Alaska Native persons can be an effective means of obtaining qualified professionals and paraprofessionals.

Diagnostic Process

Another issue centers around the diagnostic process itself and the methods used to determine if a child is handicapped. The law specifies that a multidisciplinary team approach be taken in order to provide for the diagnosis of "all areas related to the suspected disability." This approach is especially important to American Indian and native Alaskan children. Actual practice often excludes the use of more than one professional. That one person is usually the professional that certifies primary handicapping conditions. In early childhood settings this is typically due to lack of access to trained professionals as well as fiscal resources. If, however, an education setting is cooperating with a State Education Agency or the Bureau of Indian Affairs in the implementation of P.L. 94-142, the lack of fiscal resources or human resources cannot be used as an argument for noncompliance with the law. Recommendation. A multidisciplinary approach should be used. Information obtained from parents and teachers, observations in the educational and community environment, and information obtained from other service providers (e.g., social services) should be obtained. This will serve to alleviate any potential problems relating to over-identification or under-identification.

Referral Criteria

An issue that is specific to screening, diagnosis, and assessment is the problem some programs encounter in the referral of potentially handicapped children. What criteria are used for referring children, especially mild to moderately impaired children and potentially seriously emotionally disturbed children? It has been brought to the attention of special educators that whereas a child might be considered "different" or "handicapped" in the dominant white culture, the same child is readily accepted in the Indian community and in the education systems within that community. This creates a dilemma for administrators and special educators who seek to deliver the appropriate and essential special education services which can only be made available to the child after eligibility has been determined. This is an instance where community norms and expectations, parental wishes, and the child's welfare must all be considered.

Recommendation. There is a need for informed program-level individuals who are knowledgeable about or trained in the following areas: 1) P.L. 94-142; 2) special education; 3) regular and American Indian/Alaska Native education; 4) cultural and language differences of the community; and 5) diagnostic and assessment processes. Often the strategy of involving several persons in the referral of a child proves effective in resolving this problem. Using a multidisciplinary or child study team approach that involves parents, special educators, regular or American Indian/Alaska Native educators, persons knowledgeable about the community and language, or other appropriate individuals can serve to work through the problem with the ultimate decision being based on the individual child's needs. Using this approach prevents a unilateral determination of the child's needs being made by one party to the dissatisfaction of another, and possibly, to the detriment of the child.

SUMMARY

It is evident that careful attention must be given to the screening, diagnosis and assessment of preschool American Indian and Alaska Native handicapped children. In order to ensure that those eligible children are appropriately identified as handicapped and, ultimately, appropriately served, it is imperative that individuals planning services for these children become familiar with the principles underlying each of the three activities. In addition, understanding the procedures and techniques used in the three activities; recognizing the importance of the involvement of trained professionals; becoming familiar with the use of instruments -- both formal and informal; and understanding the relationship of the activities to P.L. 94-142 to the culture and language of the community will all facilitate the development of strategies that will ensure the delivery of appropriate services to young handicapped American Indian and Alaska Native children.

The issues presented are some of the most common that arise as individuals begin to plan programs and, more specifically, the screening, diagnosis, and assessment components of programs. These issues need to be considered and resolved in order for programs to ensure the delivery of quality services. Hopefully, the definitions, requirements, and principles; the sample system; and the suggested recommendations on the issues can be of assistance in meeting the needs of American Indian and Alaska Native children.

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CHAPTER 3

Planning for Individual Child Services by
Gail Weaver

OVERVIEW

When an American Indian or Alaska Native child has been identified, through an appropriate diagnosis, as being handicapped, our primary responsibility to this child is to provide an educational program that is appropriate and based upon the child's individual needs. By identifying a child as handicapped we are saying that he will be unable to participate in specific educational activities without specialized help. His needs are different than other children's needs and we must plan a program that will enable him to learn to his greatest potential. We need to identify how he can learn best, in what setting, and with what resources.

To fulfill all of our responsibilities, the educational program we develop must be highly responsive to the child's individual needs. An individualized education program (IEP), mandated by P.L. 94-142, the "Education for All Handicapped Children Act" is to be developed for each identified handicapped child. The IEP, the topical focus of this chapter, is a written statement of the child's educational needs and the program designed to meet them. It must allow the child to learn and grow to the best of his potential.

P.L. 94-142 specifies five areas which must be addressed in each IEP.

These areas constitute minimum requirements to be in compliance with the law:

1. A statement of the child's present levels of educational performance;
2. A statement of the annual goals and short-term instructional objectives;
3. A statement of the specific special education and related services to be provided, who will provide them and where they will be provided;
4. The projected date of initiation and anticipated duration of services; and
5. Appropriate evaluation procedures for determining whether instructional objectives are being achieved.

Additionally, the law calls for each public agency to initiate and conduct meetings for the purpose of designing, reviewing, and revising the child's IEP.

This chapter examines two main topics that pertain to the individual plan. The first is that of the context for developing the young handicapped child's IEP. The second topic involves a description, in more detail, of the five areas which constitute the IEP.

IEP DEVELOPMENT

The IEP must be developed through a team meeting which includes a program administrator or representative of the school (principal), the child's teacher, the child's parent or guardian, and the child (when appropriate). The parent or school may invite other people to the team meeting who can help in providing information for appropriate program planning. Included in this group should be any diagnosticians or specialists working with the child.

Each member of the team contributes in a specific way to the development of the IEP. The diagnostician(s) is responsible for providing information about the child based on a complete diagnosis or evaluation. The child's primary handicapping condition and his specific educational needs should be presented by this person. The role of the administrative representative of the school (or program) in the team meeting is to coordinate the resource specialists, the educational specialists and the school programs. This person's responsibility is to commit school (or program) resources to assure accurate implementation of the IEP. The child's teacher provides information on the child's ability to develop and learn in a variety of settings. The parent or guardian is an invaluable source of general and specific information about the child as well as being his first and primary teacher.

The membership and functions of the team meeting need to be reviewed carefully as preparations are made to deal with preschool American Indian and Alaska Native children and families. The meeting is designed to facilitate open communication among all of the participants. Many parents of these children need an interpreter to understand the information presented because their native language is not English. Moreover, the information about the child must be explained in terms that the parents can understand. The parents need to be informed of their right to question any of the information or change any of the program presented to them. The team meetings need to be set up at times and places where the parents can attend. This may mean providing transportation for parents as well as arranging to hold meeting at night or during the lunch hour. If a parent cannot attend the meeting after repeated efforts to obtain his or her participation, a surrogate parent may need to be assigned to the child to protect both the child and the parent's interests. A surrogate is extremely important in boarding schools.

During the team meeting, the total IEP is developed and finalized. It is likely that prior planning meetings were held; this will vary with the child, his needs, and degree of input required. Only with input from all of the team can a complete program based upon the child's needs be written. To assure that a total and appropriate individualized program plan is developed, each of the five areas discussed in the remainder of this chapter should be addressed.

CONTENT OF IEPs

Stating Present Levels of Educational Performance

This statement is based upon information gathered from the diagnostic evaluation, the child's teacher, and the parent. It should include a brief description of the child's abilities in all areas identified for diagnosis and evaluation. The statement should give an accurate picture of the child's educational abilities and be written in a form which can be easily understood by parents and others involved in the IEP process.

No single assessment device should be used to determine current levels of performance. In addition to academic performance, the assessment may include statements concerning motor development, vision, hearing, communication skills, social skills, health, self-help and vocational skills. The levels of functioning should be described in terms of test scores and with narrative descriptions of the child's performance.

By describing the child's strengths and weaknesses, the team can determine the type of program and the type and extent of related services needed to meet the child's individual needs. This information is essential in developing a comprehensive program.

With American Indian and Native Alaskan children, it is imperative that test results be considered in relation to the child's language abilities and culture. To use biased results in program planning can be disastrous. It is also extremely important with these children that findings be stated in descriptive terms which the parents can understand.

Stating the Annual Goals and Short-Term Instructional Objectives

Annual goals are the targets toward which a child's educational program is directed. They are broad and usually include expected educational outcomes for one academic year. To select appropriate annual goals, information such as the nature and severity of the handicap, the child's specific strengths, his rate of learning, and behavioral factors need to be discussed by the team. An annual goal for a speech handicapped child might be: Will improve the intelligibility of the child's conversational speech.

Short-term instructional objectives are the smaller, specific units of learning which will be taught in order to achieve the broader, long-range goals. These objectives must be written in a format which allows them to be consistently measured and evaluated throughout the year. Included in each objective should be the child's observable behavior, the conditions under which this behavior should occur, and the criteria for mastery. A short-term objective for a speech handicapped child might be: To produce the /s/ sound in imitation in the initial position of words with 90 percent accuracy over three consecutive sessions.

American Indian and Native Alaskan children need to have objectives written for them that incorporate pertinent native customs or practices. This means that the people who write the goals and objectives must be familiar with the customs and practices of the child and his family. The goals and objectives must be written so that cultural conflicts do not present an obstacle to achievement of the written objectives.

Stating Specific Educational Services to be Provided, Who Will Provide Them and Where They Will Be Provided

A handicapped child needs to receive his education in a setting that will help him reach his potential, a setting appropriate for his age and handicapping condition. Program options are listed in Figures 1 and 2 for the least to the most restrictive environments. The least restrictive environments allow for placement of handicapped children with nonhandicapped children. Placement should be made in the least restrictive environment

FIGURE 1

PROGRAM OPTIONS FOR 0-2 YEAR OLD CHILD

Least Restrictive — Most Restrictive

Home Programs Conducted by Parents and Home Visitor	Home Programs With Intermittent Resource Programs	Special Education Placement with Home Programs	Self-Contained Special Education Program	Out-of-School Placement

1. Home Programs Conducted by Parents and Home Visitor. This allows the parent to be the primary teacher of the very young child, with assistance from a home visitor. The home visitor writes and demonstrates all programs, and teaches the parent how to conduct them. Home visits by the Special Services Aide (home visitor) are usually scheduled once a week. All written programs are monitored by a special education teacher or a resource specialist.

2. Home Programs with Intermittent Resource Programs. Home programs are still provided by the parent and Special Services Aide. However, additional services are needed from a resource specialist. This means the child must be brought to a resource room to be seen by a specialist on an intermittent basis. How frequently the very young child is to be seen is determined by his individual needs. Resource specialists may include: speech pathologist; hearing specialist; physical therapist; psychologist; etc.

3. Special Education Placement with Home Programs. The child is placed in a special education program for a portion of each day. Development of home programs is coordinated with the classroom teacher.

4. Self-Contained Special Education Program. Enrollment in the special education program is on a consistent, daily basis.

5. Out-of-School Placement. When a very young child's needs are so great that a regular school, special education program is not appropriate, placement in a specialized setting may be recommended. Some special settings include: schools for the blind, deaf, or emotionally disturbed.

FIGURE 2

PROGRAM OPTIONS FOR 3-5 YEAR OLD CHILD*

Least Restrictive — Most Restrictive

Regular Classroom with Support Services	Regular Classroom Program with Resource Room	Special Education Classroom with Regular School Program	Self-Contained Special Education Classroom	Home-Bound or Hospitalized Instruction	Out-of-School Placement

1. Regular Classroom Program with Support Services. The child is enrolled in a regular preschool program and receives support services according to his special needs. The support services are given in the classroom by the regular classroom teacher or trained aide.

2. Regular Classroom Program with Resource Room. Along with the regular classroom programs, the child goes to a separate room for work with a resource specialist. Resource specialists may include: speech pathologist; hearing specialist; physical therapist; psychologist; etc.

3. Special Education Classroom with Regular School Program. The child is enrolled in a special education classroom. However, when appropriate, he is integrated into regular classroom programs, such as those for physical education, music, etc.

4. Self-Contained Special Education Classroom. The child is enrolled in a classroom specifically designed to meet his special needs.

5. Homebound or Hospitalized Instruction. Special education services are provided on a daily basis at the child's home or at the hospital where he is confined.

6. Out-of-School Placement. When a child's needs are so great that regular school special education is not appropriate, placement may be recommended in a specialized setting. Some special settings include schools for the blind, deaf, or emotionally disturbed.

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* NOTE: Of course, the home setting may be used also with this age group in conjunction with the classroom.

possible for maximum learning. The final decision on placement must be agreed upon by all of the people involved in the planning, and it must be based upon what the individual child needs for learning. Short descriptions are incorporated in Figures 1 and 2 to clarify each of the program options.

To provide all of these comprehensive program options as depicted in Figures 1 and 2, appropriate personnel are needed. Resource specialists are needed to provide diagnostic information as well as to implement special programs. Possible resource specialists include: a physical therapist; an occupational therapist; a psychologist; a physician; a speech pathologist; a teacher of the hearing impaired; a learning disabilities teacher; a special education teacher. These specialists may give assistance to the regular classroom teacher in developing the educational program, or they may conduct individualized programs with the handicapped child in a special education classroom, a resource room, or a home.

In addition to the resource specialists and the early childhood special education teacher who provide specific special education programming, regular school personnel can be used to work with the handicapped child. Regular personnel who may be helpful are:

1. Bus Driver. Is special transportation needed for the handicapped child? Is he in a wheelchair? Does he need to be transported to a resource room?
2. Regular Classroom Teachers. Can the handicapped child be integrated into the regular preschool classroom for specific activities or portions of the day?
3. Regular Classroom Aides. Can these assistants be trained to implement programs written by resource specialists or the special education teacher?

4. Cook. Does the child have any dietary restrictions?

5. Physical Education Teacher. Are there gross motor programs that can be implemented by the regular P.E. teacher? Are there any P.E. restrictions?

If the handicapped child's education program takes place at the school for a portion of or all of a school day, special building and equipment provisions may need to be made, depending upon the child's handicapping conditions. Special physical restrictions of the child may mean that the following adjustments be made in the school facility and equipment: ramps for wheelchairs; special desks and chairs for classrooms; accommodations on school buses for wheelchairs; special educational materials in classrooms, etc.

The IEP must state in writing how all of the educational services will be provided. For many children, this may mean providing special service aides or home visitors who are fluent in the native language. Transportation of children to resource specialists or special programs is a very important consideration in program planning. Transportation services may need to be provided throughout a school day so that a child can receive programming from a resource specialist or special education teacher but can also be transported back home without being required to attend school for an inappropriately long period of time. Additional aides on school buses may be needed to assist handicapped children since most of the areas are rural and the transportation time is extensive.

Projecting the Date of Initiation and the Duration of Services

Although the IEP is formulated and finalized at the team meeting, it is recommended that the teacher and the diagnostician(s) prepare written recommendations for the IEP prior to the scheduled meeting. This allows the information to be well thought out and presented in an accountable format. The parents can then respond to the information presented and request any changes they feel are necessary. The date of initiation of services must be after the meeting in which the parents have agreed to all of the proposed programs. The usual duration of services is one calendar year from the date of initiation of services, and additional objectives can be added throughout the year as other objectives are achieved.

It must be made clear to parents that what is being presented at the team meeting is only a recommendation for educational services. Parents may need assistance in developing questioning skills to be able to review the IEP adequately. An additional member of the team may be a parent advocate who can help them review the information and provide input back to the other team members.

Developing Appropriate Monitoring and Evaluation Procedures for Determining Whether Instructional Objectives are Being Met

Objective criteria must be developed to ensure the appropriateness of educational placement. The criteria should be stated in the short-term objectives. As each objective is met, this completion needs to be recorded.

An annual review of the IEP by the team must be scheduled. However, a review of the total program can be initiated at any time by any of the team members. This review can lead to a revision of the IEP, a new comprehensive assessment or evaluation, and/or revised placement decision.

American Indian and Alaska Native parents need to have their right to request a review of the total program emphasized. If they are concerned about the program in any way -- including placement, personnel, programs, etc. -- they need to know how to request a review of the IEP. Again, a parent advocate may be used to help parents understand their rights.

SUMMARY

The development of an Individualized Education Program is needed to provide comprehensive services which meet the needs of each identified preschool Indian or Alaskan handicapped child. (See Appendix A for an example of an IEP.) The appropriateness of this plan depends on a dynamic team meeting in which the parents and service providers are encouraged to participate in the program planning and review. It is the school's responsibility to establish the team, provide the resource specialists and teachers, and solicit active participation by the parents. The development of a comprehensive, appropriate IEP which contains the five major elements described in this chapter will allow the individual needs of the handicapped child to be met and corresponding educational progress to be shown.

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CHAPTER 4

Parental Involvement: A Vital Preschool Program Component by *Marilyn J. Johnson*

INTRODUCTION

From the time an American Indian or Alaska Native child is born, the individuals who provide primary care and make decisions regarding the child are the parents. A handicapped child's development, to a great extent, depends on how early he is identified as being delayed and how much his parents wish to be involved in his preschool program. In this chapter, we explore the varied roles of the parent in the process of providing services to the child.

These early and formative years are of more importance to a handicapped than a normal child. It is usually the parents who are first to receive reports of their child's condition. If a child's handicap is not noticeable at birth, it may be the parent who observes delays in development as the child grows. There are questions a parent may ask such as "Why me?" or "Why did this happen to my child?" Sometimes there are answers, but mostly no one has any answers. When parents can overcome circumstances surrounding a child's handicap, they can begin to accept the situation. The next step that a parent may wish to pursue is finding help and assistance for their child.

In tribal and rural preschool programs, there is often a high turnover of professional staff. Consequently, it is of particular importance in this situation to inform parents of programs relative to their preschool handicapped children. The more they understand the services that are being provided, the more confident they will feel in providing input to the staff. And, as parents learn to provide input, the better equipped they will be to assume their varied roles -- especially as lifetime advocates for their handicapped children.

VARIOUS LEVELS OF PARENTAL INVOLVEMENT

Parents are not all alike. Many may be able to accept their child's handicapping condition because of support from families and friends while others may need other sources of support.

Before parents can start being actively involved in their child's preschool program either through meetings, parent conferences and training, the basic needs of the family must be met. The parents may look to program personnel for this support. For single parents, assistance may involve referral to social service agencies for financial help. If a program is funded to offer any assistance, a parent without transportation may be offered a ride to the clinic or hospital to pick up medication. Assistance in the form of diapers may also be needed. After a parent gets some of the primary needs addressed, very often attention can then be focused to help the child develop.

Because parents have varying needs, programs must be molded to address their concerns. Some parents may perceive information regarding their child's handicap as a basic need. Some may need to share information about their child's handicap with other parents, rather than with their families or social service agencies.

Many parents need to be assured that there are a variety of ways to cope with their children's handicaps. They may even deny the existence of the handicapping condition for a short time: this is all a part of the coping mechanism. It is important for individuals close to the parents to reassure them and to help them accept the child. It does not help anyone to say that the child "will grow out of it" or that "it will go away." Acknowledgement of the child's handicap, not "sickness," will help the parent accept the condition and face the circumstances, rather than avoid them.

Because the needs of parents vary, they become involved in trying to provide special services to their child at various levels. Examples of involvement, clustered into four levels, are shown in Figure 1. The levels reflect a range of involvement opportunities, starting at Level 1 with the most typical kinds of activities that parents engage in up to Level 4 with activities that relatively fewer parents get involved in. Short descriptions follow for each level.

Level 1

Almost all parents of preschoolers participate in this level which includes activities such as participating in referral, exchanging information, and helping in evaluation.

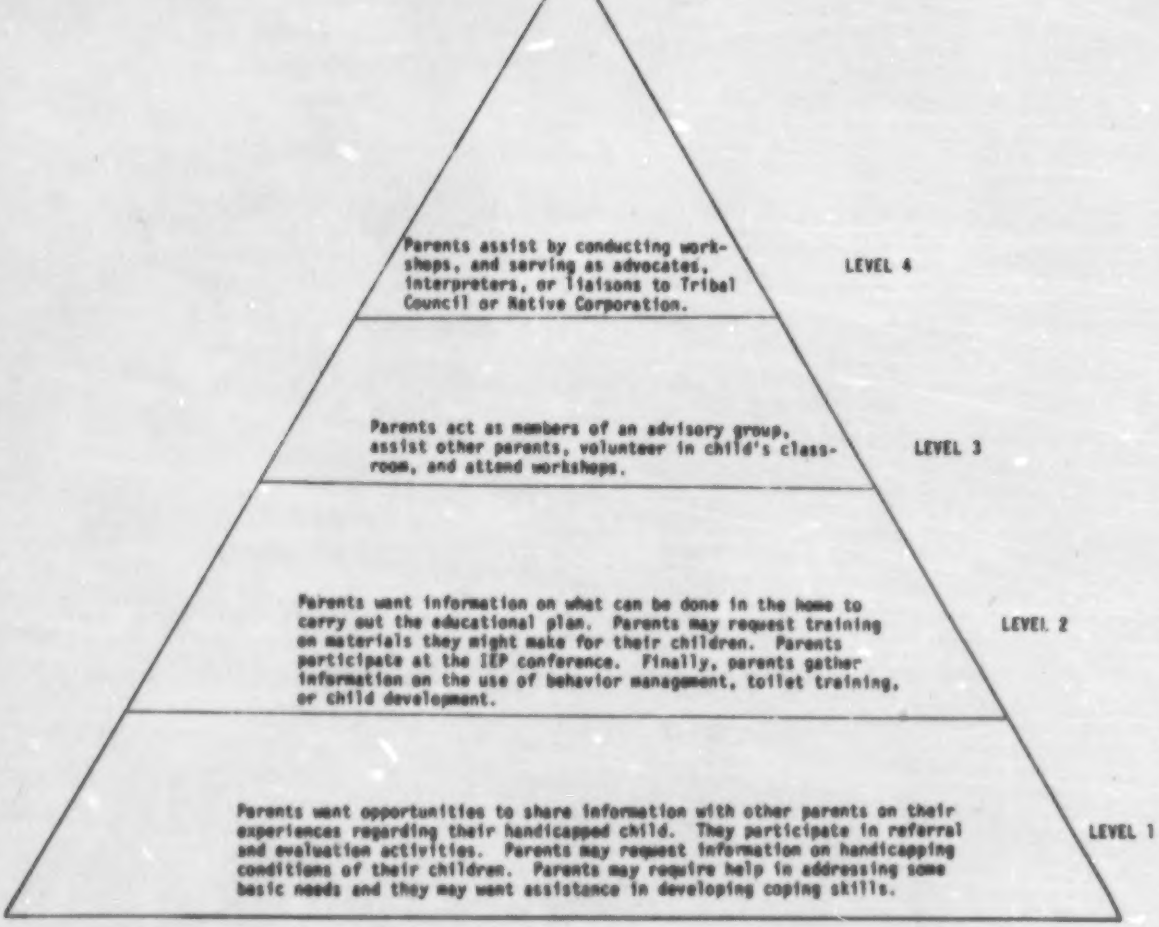
Referral and Evaluation. When someone -- such as a physician or field nurse or parent -- notices that a particular child is not developing as other children of the same age, he may suggest that the child be examined by specialists to determine if a problem exists. This is called a referral. It is usually the first step in any parent's awareness of the special services available to the child.

It is important for parents to participate fully in the evaluation of their children's needs. The preschool program must work for this participation through conveniently scheduled meetings, calls or visits to the home, and if necessary, an interpreter.

The participation is important for many reasons. First, a parent

FIGURE 1

Four Levels of
Parental Involvement



Parents assist by conducting workshops, and serving as advocates, interpreters, or liaisons to Tribal Council or Native Corporation.

Parents act as members of an advisory group, assist other parents, volunteer in child's classroom, and attend workshops.

Parents want information on what can be done in the home to carry out the educational plan. Parents may request training on materials they might make for their children. Parents participate at the IEP conference. Finally, parents gather information on the use of behavior management, toilet training, or child development.

Parents want opportunities to share information with other parents on their experiences regarding their handicapped child. They participate in referral and evaluation activities. Parents may request information on handicapping conditions of their children. Parents may require help in addressing some basic needs and they may want assistance in developing coping skills.

must give consent before developmental tests and other evaluative procedures can be used. These tests help establish the levels at which the child is functioning in many areas.

Second, the parent can often provide the evaluator with excellent information about the child's present level of development, because he is with the child for the major part of every day, while the evaluator attempts to gather information in a very limited amount of time. For example, the parent could tell the examiner if the child is able to manipulate a spoon with his left hand, or if he regularly uses certain words from his native language.

Third, it is important for the parents to be involved because the child, who is unfamiliar with the examiner, may react differently to him than he does with more familiar people like his relatives. The parents can put test activities and results in perspective.

The diagnostic process can include any one or all of these individuals: a physician, educational diagnostician, psychologist, speech pathologist, occupational therapist, physical therapist, etc.

Information Sharing. When a child with a handicap is identified and information provided to his parent, it is usual for the parent to be overwhelmed and not understand the entire explanation. Parents may wish to have the medical information explained in greater depth along with the long-term impact it will have on the child. It might be helpful to the family if this information is explained in the native language and in English. For example, the subject of genetic conditions is often more readily understood when explained in both languages. There are probably no terms in existence for words such as genes and chromosomes in American Indian languages. A group of individuals may wish to combine efforts to come up with the best possible explanation for conditions that directly affect their children. These same explanations might thereafter be used in providing information to grandparents or to other members of the tribe who cannot understand English.

Evaluation and Appraisal. Information derived from the evaluation is presented before a committee composed of the parent, the Special Education teacher or staff member from the program, the coordinator or director of the program, the educational diagnostician, and any other individuals who had a part in the evaluation process. If necessary, an interpreter can be requested.

Information is reviewed by the parent and members of the committee to determine the program options for the child. Program options can be developed by program personnel based on the needs of the child and parents. The evaluation process might also indicate that a child's needs for special education are not necessary or warranted. When this happens, the child and parents exit the evaluation process.

Level 2

This level of activity involves parents who wish to become even more involved in their preschool child's efforts in ways such as: participating in IEP development and learning to use instructional materials.

Participation in IEP Process. When a child's needs have been defined, the Individual Education Program (IEP) can be developed. The IEP is a written plan for the child, developed by the parent, special education teacher, the educational diagnostician, the program administrator and, when necessary, speech pathologist, occupational or physical therapist, medical personnel, etc. The parents can request that any individuals they choose come to the IEP conference; these people may include a grandparent, a parent of another handicapped child, a school board member, a tribal councilman or a social worker. An interpreter may also be requested to translate the proceedings.

The IEP will list goals for the child that have been agreed upon by the parent and members of the IEP committee. It will provide information on steps for reaching the goals and the time allowed for attaining the goals. It will list the staff who will be responsible for implementing the plan. (See Chapter 2.)

The parent's active participation in developing the IEP helps the program staff plan the most appropriate and workable activities for the child. It is important for the parent and staff to agree on educational priorities for the child. The parent may feel that toilet-training the child is by far the most important priority, because she has two other preschool children. The teacher, on the other hand, may feel that the child has a greater need for speech therapy. It is important for the parent and teacher to agree on the area or areas in which efforts will be directed, so that they can work together and the child does not receive a diluted program.

Specialists (speech pathologists, psychologists and occupational therapists) often use professional jargon that is not easily understood. The parents and staff can request the interpretation of this information into laymen's terms. It will result in less anxiety and confusion for both parents and staff.

Upon completion of the IEP, parent(s) and staff will have defined and agreed on the following:

- Goals and objectives for the child.
- Measurement of the objectives.
- Date for initiation and completion of the objectives.
- Type of program.

- Length of time that child will participate in program and frequency of participation.
- Dates services will begin and terminate.
- Individuals who will be responsible for implementation of the IEP.
- Placement information regarding handicapped or nonhandicapped children.

If a child needs any support services, a plan for their provision must also be included in the IEP. Some of the support services include: speech therapy, physical therapy, special transportation, recreational therapy, and music therapy. (See Chapter 5.)

After developing the IEP, the parents and members of the committee should sign the written plan. The child is now ready to participate in special education services. At any time after the development of the IEP, the teacher or parent can call for an IEP meeting if the plan is no longer appropriate or needs to be changed.

One of the major goals for special education is to help the handicapped child lead a life as normal as possible. A parent may therefore try to place a child in the least restrictive environment. In a least restrictive setting, a handicapped child may be integrated with nonhandicapped children if it is decided by the IEP committee that the child can benefit from this placement. He may be placed in a Head Start program along with the nonhandicapped children or in a preschool program. A younger child may require exclusively homebound services. As he grows and develops, a preschool setting may be most appropriate or perhaps a combination of homebound and preschool program. His educational environment may include activities involving art, music, dancing, water play, and field trips. In each case, the environment must be determined on the basis of what will benefit the child most.

In the event that a parent and program personnel do not agree on a part of a child's evaluation or placement, every effort should be made to resolve the issue at the local level. If matters cannot be resolved, an impartial hearing can be requested.

Using Instructional Materials. As parents develop more confidence in working with their handicapped children, they may want to purchase or borrow materials that are used in a preschool program. These materials and items of equipment are often costly. It would be beneficial and informative for the school to help parents learn how to make materials that might be constructed from items usually found in the home. This learning experience will provide parents with an opportunity to share information and ideas with each other. Very often parents have innovative ideas that they have already tried. Parents often find this a pleasant task. Individuals who might conduct a training session like this might be a Materials Development Specialist, a Special Education teacher, or an individual from a college or university.

Level 3

As parents gain confidence in working with their child and with the preschool program, it seems that some take on added activities or responsibilities. These include assisting other parents and attending meetings.

Parent Visitations. Most parents of handicapped children recall the impact the child had on the family. A few of these parents (Level 3) may wish to visit the parents of a newborn handicapped child to help reassure them and comfort them. It is important for these Level 3 parents to let the new parents know that they would like to visit; new parents are often not ready to talk with anyone until later. There was an instance in a tribal preschool program when a parent learned of a child with hydrocephaly (a condition which used to result in an enlarged head) being born to a non-Indian parent.

The Indian parent who had borne a child with hydrocephaly tried to comfort this parent and shared her experiences and concerns with the mother. This instance of cross-cultural sharing is not unique; children with handicapping conditions are born to people of all races.

Meetings. As children with handicaps are identified and receive services, it is helpful to schedule a meeting in which parents of older handicapped children can share their concerns with parents of the younger children. The program coordinator may wish to plan a potluck meal in conjunction with the meeting. This discussion can be very helpful as the parents of the older handicapped children share concerns and provide recommendations to the parents of younger children. No one needs to feel guilty because the Great Spirit has chosen certain parents to care for these children.

Sometimes in these meetings parents feel more comfortable talking in their native language. In our program, one of the parents shared his experience of how a social worker tried to convince him and his wife of the better alternative for their handicapped child: institutionalization. The father informed this non-Indian professional that they had no intention of sending their daughter anywhere and that no one with such "better" ideas need come back. Sessions such as these seem to work best with small groups of parents.

Because non-Indian professionals may have ideas of how American Indian handicapped children can best be served that conflict with Indian preferences, sessions such as these can help the parents determine -- through discussion with peers -- what they perceive to be the best program for their handicapped child.

Level 4

Some parents, usually a small number, participate in the last level of activities. It is at this level of involvement that parents operate or assist in workshops, serve as liaison representatives with decision-making bodies, and act as parent advocates.

Parent Advocates. As they become more involved, parents may want to assume the role of a parent advocate. Responsibilities may consist of accompanying new parents to an IEP meeting. Input at such a meeting might consist of describing appropriate delivery of services (including related services). When parents have enough information about federal requirements for special education, they can readily see if funding for appropriate services is available. Advocates can be helpful when parents are considering a request for a hearing.

CONCLUSION

A vital component of any program serving American Indian and Alaska Native preschool handicapped children is parental involvement. This chapter sought to describe some of the various types of parent activity. Activities, arranged into four levels, ranged from referral/information sharing, IEP conference/using instructional materials in the home, workshop/advisory groups, to liaison with the tribal council or native corporation, and being a parent advocate.

Regardless of the activities, preschool program leadership personnel must plan systematically to involve parents. Casuso (1978) suggests to planners that a cooperative spirit must prevail when working with parents. She further recommends that one must get to know parents as individuals, as well as listen to their concerns and interests. She states:

> Since it is essential to establish rapport and a feeling of trust, approach this relationship by accepting the parent in a non-judgmental manner and by communicating an atmosphere of acceptance. As a result of careful and sensitive listening, the interventionist should then be able to help parents identify

their needs and interests. Based on this assessment, the interventionist is then in a position to take positive action to help parents in those identified areas, helping parents help themselves by providing an opportunity for learning experiences (p. 18).

REFERENCE

Casuso, V. Working with Families of the Preschool Handicapped Child in Spanish-Speaking Communities. In Trohanis, P. (Ed.) Early Education in Spanish-speaking Communities. New York: Walker and Co., 1978.

CHAPTER 5

Planning for and Implementing Specialized (or Related) Services by *Joseph S. Caldarera and Louena M. Guidera*

> It was minus forty degrees in the village of Kwigillingok, Alaska, but the sky was blue and the air was fresh and exhilarating. Pavilla Bayayak felt excitement as he hooked his dog team up to his sled so he could get out and check his fish nets. The village was small, less than 250 people, and life at times was austere and difficult, but the land was bountiful and provided all that was necessary for survival.
>
> As Pavilla headed out on the trail, he noted a rather unusual occurrence. Overhead and to the north and west, he saw six small engine aircraft shooting their final approaches to the small dirt airstrip. It was common to see two, even three airplanes at one time but this was most strange. Before departing on his trip, Pavilla decided to wait and see what the special occasion was. Within thirty minutes, all the planes had landed and their passengers had disembarked.
>
> Out of each plane walked a tall, bearded well-dressed white man carrying a small rectangular suitcase. Obviously the white men were not from the area. As the men negotiated through the snow drifts, Pavilla noted that all were heading towards the building where the Head Start Program was housed. The men reminded him of penguins walking in a row.
>
> Independently and without the knowledge of the other, six local and state service agencies had sent audiologists to the village to evaluate the hearing status of each of the fourteen children enrolled in the Head Start program. All of these children had been tested by another service provider just six months earlier, but the test results were never distributed to the agencies. The total cost of the hearing testing this day would exceed $2,500. Pavilla Bayayak caught many fish that day and he looked forward to his evening meal. Tomorrow, he could check his fish nets again, just as he had always done.

This story is fictitious, of course, but the scenario is within the realm of possibility. It depicts, for many areas of this nation, the lack of planned coordination between agencies providing specialized services to handicapped and potentially handicapped American Indian and Alaska Native preschool youngsters. The absence of interagency coordination often results in costly duplication of services, interagency competition, failure to provide services to special needs children in a timely manner, and, in some cases, failure to provide these services at all. The purposes of this chapter are to define the specialized identification, assessment, treatment and other support services needed for young handicapped children and to discuss why these services must be provided, who should provide them and how more and better services can be delivered earlier to American Indian and Alaska Native preschool children.*

We believe that every individual, organization and human service agency has a role in the process of constructing and advancing community patterns of specialized-related services for handicapped preschool children. And, we believe that improved interagency cooperation is crucial to the delivery of these services. Thus, emphasis in this chapter will be placed on tangible ways for early childhood education planners -- including Head Start directors, public and BIA school administrators, local tribal organizations, native corporations and other educational planning bodies entrusted with the responsibility of delivering educational services to handicapped American Indian and Alaska Native children -- to plan and deliver quality specialized services to preschool children cooperatively. Hopefully, the following discussion will provide the kinds of information service providers will need to promote community understanding and to support delivering these services in a well-managed fashion.

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* In order to simplify references to these various kinds of services, the term "specialized-related services" will be used throughout this chapter.

SPECIALIZED-RELATED SERVICES:
WHAT THEY ARE AND WHY THEY ARE NEEDED

Within the group the world calls "young handicapped children" is found a wide variation of disabilities and conditions. Each disability requires educational services to be delivered in a special way (LaCrosse, 1975), because each child may have one or more disabilities which interferes with normal physical, intellectual, emotional and/or social development. The handicaps may be mild, moderate, severe or profound in degree. They include: specific learning disabilities, mental retardation, neurological and orthopedic impairments, communication disorders, chronic health impairments, blindness, visual impairments, deafness, hearing impairments and severe behavior disorders. When two or more disabilities are present one may act in concert with another to produce multiple developmental delays.

The law that guarantees all handicapped children a "right to education" establishes once and for all the necessity of an individualized approach in designing a comprehensive education service delivery program for each handicapped youngster, including the handicapped preschool child. This program must include specially designed instruction and those related services required to help the child benefit from special education. Specialized-related services are defined in P.L. 94-142 as:

> ... transportation, and such developmental, corrective and other support services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic and evaluation purposes. The term also includes school health services, social work services in schools and parent training and counseling (Federal Register, 1977, p. 42479).

Both the educational objectives and the specialized-related services detailed in the individual education program for any handicapped youngster must be derived from a careful evaluation of the child and his or her environment. While ethnic and cultural differences found among American Indian and Alaska Native children remain a conspicuous and substantial challenge to these evaluation and intervention-planning processes, all human service disciplines have an obligation to contribute their special skills to accommodate the diversity of needs these children represent and to make the promise of an exciting and life-enhancing education for them a reality. Specialized evaluation should culminate in a composite of recommendations and prescriptions. These must help parents and educators to decide how to help an individual child learn what he or she is ready to learn in the way he or she learns best.

A glossary containing some of the many kinds of specialists who can and should become involved in the provision of these services to young children with special needs is included in Appendix B. These specialists come from a variety of settings such as hospitals, clinics, schools, private practice, and special project programs.

The education agency that has the primary legal responsibility for the provision of specialized-related services to handicapped American Indian or Alaska Native children in a given locale must ensure that these services, often the major part of programming are delivered to the preschool child. However, in many areas of the country, it is not jurisdictionally clear who has the ultimate responsibility for providing specialized services to American Indian and Alaska Native children in this age group.

It is important to note that while the specialized-related services needed by any handicapped child are to be determined without regard to the availability of those services, practical restraints on local resources -- human, fiscal and material -- have a tendency to shape what is actually implemented in preschool programs designed to mainstream handicapped Alaska Native and American Indian children. For example, early childhood education programs for these children are for the most part located in isolated rural areas. The consequence is that the quality and quantity of education and specialized-related services for them and for their families varies as does meaningful and career-enhancing experiences for the administrative, instructional and support personnel serving them.

The Need for Specialized-Related Services

The need for specialized-related services may best be understood by describing a composite Native American handicapped preschool youngster. The following child, a girl who might come from a rural community in many parts of this country, is undoubtedly known to several public and private human service specialists:

> Five-year-old Bird Song, diagnosed as a mildly mentally retarded child with high levels of anxiety and low levels of trust in personal relationships, has attended a tribal Head Start program for the past two years. There is no kindergarten in this youngster's small community which is a great distance from the Head Start Center
>
> Prior to this year, Bird Song had been in and out of temporary homes and attendance at the Head Start program was sporadic. The child is now living with her natural parents and two younger children. The father is deaf and specific concerns have been expressed about the inability of the family, particularly Bird Song, to communicate with him effectively. A counselor, experienced with the deaf and fluent in manual communication, has been located -- 150 miles away.
>
> Bird Song exhibits delayed language and a significant visual problem. This child wears thick, prescriptive glasses and is followed at the local Indian Health Service specialty clinics for a heart murmur and for chronic ear infections.
>
> Bird Song has made great gains in all areas of development this year and can manipulate most preschool materials quite

> easily, having difficulty only when she cannot see clearly what to do. Self-help skills are at a level close to that of other five-year-old children. While motor skills appear somewhat below age level, this is believed to be due largely to Bird Song's visual limitations. In socialization areas this child is closer to age level than she was a year ago and now plays "with" rather than "by" other children. Bird Song's vocabulary has increased impressively and she has become an enthusiastic, if not rapid, learner.

While the profile of Bird Song is a composite one, it represents the varied needs of many of the children currently being served in early childhood programs throughout this nation. Often, one handicapping condition in a young child is accompanied by another. When two or more disabling conditions exist, one may be an obstruction to remediating or improving the other. Uncorrected physical conditions such as Bird Song's visual problem and chronic ear infections may, without proper intervention, have prevented this child from meaningfully exploring his or her environment and learning. In such cases, the very best early childhood education program activities will fail. Many conditions, if recognized early enough, can be corrected or improved to the degree that the child's ability to learn is greatly enhanced (Fallen, 1978).

The specialized services required by Bird Song and her family are by no means the extent of the services required by American Indian and Alaska Native preschool handicapped children. But, hopefully, Bird Song's profile conveys clearly that the nature of this population dictates that neither one group of educators nor any other single concerned professional group is able to provide all the input necessary (Connor, 1973) for effective services. Regular teachers, early childhood teachers, special educators, day care service providers, parents and other primary caretakers rarely possess, at least initially, all of the technical skills required to manage many of these children. Some parents and teachers may not even realize the presence of a disability nor that a child with several mild handicaps may have a more difficult time of it than a child with one obvious or serious disability because of the interplay of the problems.

Furthermore, there are scores of handicapped preschool children who may be so young, health-impaired or multiply-handicapped that they cannot attend and/or benefit from center-based preschool programs. Similarly, some preschool handicapped children may not have access to a center-based early childhood program or may have parents who elect not to have them participate in available programs. Services must be provided to these children in the home. They most often include therapeutic stimulation, nurturing, and health management. Delivery of the services requires the assistance of several specialists and/or technician-level personnel trained to work in a home-based setting.

It is also important to note that many of the specialized-related services required by preschool handicapped children and their families now, may continue to be needed by them with variation at other stages of or throughout their lives.

PLANNING FOR IDENTIFYING AND OBTAINING NEEDED SERVICES

Just as a preschool child must develop specific visual and motor coordination skills before using scissors correctly, an early childhood program must develop conditions of readiness before it can effectively secure the specialized-related services and personnel needed for its handicapped population. Program planners for American Indian and Alaska Native handicapped children must demonstrate their understanding of the importance of needed specialized-related services by establishing priorities to identify and to obtain them in an orderly fashion.

Common Problems in Delivering Services

Several factors affect the availability and accessibility of needed resources and services for handicapped preschool children in many Indian communities and Alaskan villages:

- A general paucity of local and qualified specialists experienced in working with young handicapped children and their families in rural, sparsely populated areas.
- A lack of cooperative interagency attempts at the local level to secure needed specialized-services personnel. The result is time-consuming and nonproductive independent recruitment of credentialed specialists by local health and education agencies.
- Delays in the scheduling of available services directly associated with problems of jurisdictional overlap. In other words, "Who is responsible for providing what services to whom?"
- Strong competition in attempting to secure what limited special services do exist. This happens when all age segments of the community are vying for the same services.
- A subtle resistance to the provision of some special services through established early childhood education programs and other funded day care facilities. This can occur when uninformed community leadership perceives these programs as providing services to their preschool population at levels which satisfy local needs.
- Other problems in acquiring services. These are based on variables such as geographical distances, remoteness from metropolitan areas which limits the "visibility" of special needs children and families to service providers located in these areas, severe weather, hazardous road conditions, lack of housing and political community instability.
- Denial of specialized-related services. This is a silent, often

unknown problem since the mere provision of basic day care, Head Start and/or other preschool programs may constitute in their own right, a significant accomplishment toward providing basic services to preschool children.

- The opinion, among professionals, that the specialized, high-cost treatment needs of preschool handicapped children, particularly with reference to birth to three-year olds, are not the concern of the educational agency. This attitude exists in public as well as federal school systems. This attitude also exists in states that have compulsory education laws for birth to five-year olds as well as states not having these laws. Without advocates, this out-of-school population is often neglected by some educational agencies, thereby interfering with the delivery of specialized-related services to these children.
- The provision of specialized-related services after basic instructional services have been afforded to children. Provision of basic, direct instructional services to school-age children with teachers and aides is very expensive and often there are no funds left to hire support personnel that can deliver related services. Because of the secondary status bestowed to specialized-related services coupled with the inadequate funding base to provide these services, school districts -- both state and federal -- find it difficult to provide specialized related services to their handicapped population including

preschool children.

- Purposive historical isolation which directly interferes with the provision of a full service special education delivery system to Native American children. The need for interagency coordination and cooperation is acute. Until this coordination is a reality, some services will continue to be denied, others will compete with each other for funds, and equal and appropriate educational services for Native American preschool handicapped children will be inadequate.

Furthermore, developing cooperative relationships necessary for effective specialized-related services is more often than not affected by attitudes. A myriad of service agencies have traditionally delivered and continue to deliver health and education services to American Indian and Alaska Native populations. Unfortunately, "a sense of status and power may bring a large, long-established (service) organization to surround itself with rather arbitrary policies and procedures which put others interested in establishing contact in the role of petitioners" (Dybwad, 1964, p. 9). Reactions to this posture often create breakdowns in communication and interfere with the provision of services not only to handicapped preschool children but to all segments of the Native American community.

Determining Needs for Specialized-Related Services

Prior to developing a plan of action to secure specialized-related services for handicapped preschool children, program planners must gather pertinent needs assessment information about the size and scope of their local preschool handicapped population and the local resources available for this group. Importantly, the development of service delivery plans must be in tandem with objectively defined child-centered needs. The kinds of information which must be compiled before beginning local program efforts to obtain needed services are:

1. The approximate number of children in your service population, known and projected, and the actual and/or possible disorders and conditions they exhibit;
2. The ages of these children and the assessment data currently available for them which may be shared with specialized resource personnel;
3. The specialized-related services needed by these children and where by program site these children are located (center-based/home-based);
4. The method used to determine the child-centered needs of this population and by whom these needs were identified;
5. The kinds of specialized-related services currently being provided to these children;
6. The additional kinds of specialized and related support services you currently need and anticipate needing;
7. A ranking of the services most critically needed by your population and a timetable for meaningful acquisition of these services;
8. Assuming resources are limited, the population of children who will go unserved;
9. The location at which services will be provided and any factors which would insure or impede the delivery of services such as housing, transportation, etc.;
10. The anticipated level of parent and staff participation for information and/or training experiences;
11. The anticipated follow-up service, therapy and training activities needed; and,
12. The services currently available in the local area including

documentation of appropriate contacts for these services.

Once local program needs are thoroughly identified, an additional fact-finding step should be undertaken by program planners before attempting to secure services. This step is to obtain specific information from various resource agencies about their services in order to determine what agencies can best assist in the development of a specialized-related service delivery program for the local program. The following types of questions should be asked in order to make this determination:

1. What types of medical, diagnostic and/or therapeutic specialists are available from the agency?
2. Are the specialists licensed or state/board certified?
3. Have the specialists had any experience working with American Indian or Alaska Native children?
4. What are the consultant costs, if any, and what type of reimbursement procedure is required? Is there a daily consultant fee or a per child fee?
5. Can the agency insure that the consultant services will be provided on a consistent, ongoing follow-up basis?
6. What are all associated costs, i.e., per diem, travel, material fees, equipment rental fees, clerical fees and others?
7. What specific types of disabilities can the agency effectively work with? Does the agency specialize in providing treatment/diagnostic services for one or more types of handicap?
8. What restrictions does the agency place on the transfer of client data, especially to third parties?
9. With what age range do agency personnel have experience? Have they worked with preschoolers?

10. Will the agency provide on-site inservice training to field implementors, i.e., Head Start teachers, parents, instructional aides, nurses aides, nurses, teachers, etc., so that therapy activities can be continued in the absence of the specialist?

After this information is gathered, it is much easier to select the most appropriate resource agencies for the delivery of specialized-related services -- the agencies that will and can provide the needed assistance to preschool children at an affordable cost.

Consideration must also be given to monitoring the acquisition and implementation of specialized-related services. This monitoring system should include a person(s) designated to collect appropriate data. This information will assist program planners in evaluating the effectiveness of these services and the efficiency of their delivery modes. It will also generate the kinds of information necessary for future planning.

KEY RESOURCES FOR SPECIALIZED-RELATED SERVICES

Developing realistic goals and exemplary special services for American Indian and Alaska Native children depends on the quality of information gathered from appropriate specialists to compose the individual comprehensive services plans for these children. Similarly, the implementation of instructional and specialized-related services for Native American preschool children and their families will also depend on a finely meshed network of resource personnel who know the population they are serving and the environment in which these services will be delivered. Furthermore, all individuals recruited to deliver services to these children in general must embrace not only the legal responsibility to include parents in this process but also the moral imperative to make them keystones in the arch of services provided to their children. This concept is perhaps more articulately stated by Gorham et al. :

> ... the obligation for the parent to become "expert" on the needs of his own child will always be present. No one can do that for him, and he will require the help of professionals to become expert. Professionals, in turn, will have to accomplish a major switch in their thinking and look upon themselves as consultants to parents, with the principal obligation of sharing their particular expertise with the parents of the child whom they diagnose, treat or educate. It is a new look which makes new demands on the professional and somewhat different, but not substantially more difficult, demands on the parent. Certainly the prospect of a better informed, more understanding parent raising a child with more clearly defined rights holds far more promise for the futures of children with disabilities than past practices (Hobbs, 1975, p. 187-188).

Clearly, well-designed provisions for the meaningful inclusion of parents in all aspects of the services provided to their children are essential to changing the contemporary system of delivering these services to Native American handicapped children and their families.

What follows is a categorical grouping of some of the agencies, organizations and other key resources that can, with careful planning, be mobilized along with parents to assist in meeting the special needs of handicapped American Indian and Alaska Native preschool children. Possible advantages and disadvantages in utilizing the service delivery systems of agencies or organizations listed in each grouping have been included.

Federal Agencies

Federal agencies such as the U.S. Public Health Service and the Bureau of Indian Affairs are entrusted with the responsibility of serving Native American people and are experienced in working with these populations. While local Indian Health Service Unit and BIA Agency personnel vary in number, kinds and level of experience at any given site, general and specialized health care, diagnosis, treatment and social services are available at most sites. Both agencies can contract with other public service providers and private practitioners for needed services in their cachement areas.

Maternal and Child Health Service Clinics which are federally supported "well baby" clinics are sometimes located at and work closely with the Service Units as do woman-infant-child programs such as WIC which is a nonschool food and nutrient-intake monitoring program for young children.

Possible Advantages:

- Related diagnostic/treatment services are usually free.
- Once service agreements are made, there is usually easy access to continued follow-up activities.
- Agencies are experienced in working with Native Americans.

Possible Disadvantages:

- Local capabilities differ widely. Some hospital and agency sites can offer a wide variety of specialized-related services, some can offer none.
- Diagnostic/treatment personnel though highly trained are not always equally experienced.
- Often a long waiting period between a request for services and service delivery is present.

State Agencies

State agencies and the programs they fund generally offer a wide variety of specialized-related or support-service resources for handicapped preschool children. Different states have different names for the same departments or divisions that provide these programs. Many are required by statutory mandate of state court decree to serve handicapped children and youth. Others exist solely for that purpose. Some of these state resources are Departments of Health, Education, Public Welfare, and Public

Institutions. State Departments of Education have a Special Education section and branch programs related to specific handicapping conditions such as communication disorders, specific learning disabilities, and mental handicaps. There are also state programs for the blind, deaf, and severely multihandicapped. Most states have Crippled Children's Services which are federally supported, and state-operated clinics for children and youth with a wide range of physical and mental impairments. Early and Periodic Screening Diagnosis and Treatment (EPSDT) is another valuable resource available for many American Indian and Alaska Native children. These are federally-assisted state programs providing health and developmental assessment and treatment services for income-eligible children by designated service providers.

Possible Advantages:

- Services are usually free or low cost.
- Diagnostic/treatment personnel are usually well trained, licensed or certified, and experienced.
- Many of these agencies work with specific disabilities, hence, specialization may increase the quality of the service.

Possible Disadvantages:

- Offices and specialists are generally located in large communities or cities thus making these services difficult to obtain for children residing in isolated rural areas.
- The waiting period between referral and delivery of services can be substantial.
- Follow-up services may be difficult to schedule and obtain.

Local Agencies

Local school programs for handicapped preschool children vary according to community needs and the existing practice, statutory, or other legal requirements of the area or agency to serve children in this age group. A common denominator, however, is that the school superintendent or equivalent administrator in each school system -- public, federal, or tribal -- is assigned the responsibility for special education services and is often a key resource for information about specialized and related support services available for young handicapped youngsters in that system and/or geographical area. Since local schools are in the "business" of providing many kinds of educational activities and services, there may exist a number of specialized and related support personnel who can be tapped as resources for handicapped preschool children and their families.

Jurisdictional overlaps, interagency conflict and other variables have historically impeded cooperative efforts between local public school districts and federal/tribal education units. However, local public school districts in many parts of the country operate comprehensive special education programs including a full scope of support services. If external agencies asked to participate in the specialized-related service programs of these local school districts on a cooperative agreement basis, American Indian and Alaska Native handicapped preschool children and their families could receive more services.

Possible Advantages:

- Personnel are certified.
- Subsequent to cooperative preliminary interagency planning, local school districts can assume the bulk of the administrative planning functions, thus, receiving agencies can concentrate on getting instructional services to children rather than concern themselves with recruitment, payroll, and other operational concerns surrounding support staff or support services.
- Entering into cooperative service agreements tends to breakdown

historical boundaries hindering interagency coordination. As federal BIA/tribal agencies begin to work closely with state or local school districts, greater efficiency, goodwill, and standardization of educational programs is facilitated.

Possible Disadvantages

- While special services school personnel are accustomed to working in an educational setting, most are not experienced or trained in working with preschool children
- Because so many "levels of approval" are required by federal, state and local agencies, development of cooperative service agreements can be costly, time consuming and lengthy, exhausting patience at times. Frustration can easily follow.
- Cooperative agreements can have a short life span thereby disrupting the continuity of related services delivery as federal, state and local agencies often depend on year-to-year soft money allocations for provision of related services.

Metro Agencies

There are other local agencies in many metropolitan areas that can provide a variety of specialized support services. While many nonprofit organizations rely on volunteers, others are privately owned or endowed facilities. Most are staffed by dedicated citizens and members of many professional disciplines. These agencies include private kindergartens, medical and therapy clinics, day care and child development centers, neighborhood health centers, local social service agencies, respite care providers and agencies providing transportation services for the handicapped.

Possible Advantages

- Services, provided by nonprofit agencies, are generally low cost or are free.

- Agencies are usually staffed by concerned dedicated personnel.
- These agencies are usually easy to work with, are enthusiastic about accepting clients, and have a minimum of administrative complication. The agencies are usually not part of a large governmental bureaucracy.

Possible Disadvantages:

- Because local agencies serve local/city residents primarily, the services are often not available or readily accessible to children who live in rural areas.
- Personnel may not be experienced in working with Native American children from rural areas.
- Services provided by private profit-making clinics and schools can be very expensive.

Universities and Colleges

Many university and college personnel and the students they are training can and do provide specialized services in areas such as child development, special education, social work, child psychology, speech pathology, physical and occupational therapy, audiology and nutrition. Some of these colleges and universities are associated with hospitals or medical centers and can provide services in other professional disciplines such as medicine, dentistry and nursing.

Colleges and universities usually provide diagnosis, treatment, training and/or consultative services to programs serving preschool handicapped children based on the particular institution's service program goals and objectives. Most institutions of higher learning are anxious, however, to provide their students with a wide variety of field-based experiences, and many provide services to American Indian and Alaska Native children via students who are accompanied by credentialed professional personnel to local community settings.

Possible Advantages:

- While costs for services vary considerably, many are often minimal.
- Personnel are usually enthusiastic, well trained and have access to the most modern tests, equipment, and research information.
- If service proves to be reliable, there is usually a continuous supply of personnel.

Possible Disadvantages:

- Student interns are usually not experienced, certified, or licensed. The quality of services may not be at parity with a professional level of services.
- Availability of specific services varies considerably and if student interns are utilized, there is little or no personnel continuity in the delivery system.
- University training programs often do not train specialists to work with preschool handicapped children. Services therefore may not be totally appropriate for the preschool child.
- Interns may have no experience with American Indian/Alaska Native children.

Regional Service Centers

Many states have regional educational service centers which may be called Regional Resource Centers, Educational Cooperatives, or Intermediate Service Centers. These units offer some of the most viable and important sources of support services for handicapped preschoolers. Typically they offer the services of school psychologists, audiologists, speech pathologists, deaf/blind education specialists, and others. They also offer inservice training programs, educational materials, screening, testing and other technical assistance.

Resource centers differ from state to state in how they administratively function in a geographic service radius. Most often they perform consultant services on a contractual basis for consumer members.

Possible Advantages

- The professional staff members are almost always trained educators well versed in the needs of handicapped children. As trained educators they can provide a high quality of services to preschool children.
- Consultant fees are generally reasonable. It is easy to enter into cooperative service or contractual agreements as there is usually a minimum of administrative red tape. Services are offered in a timely, efficient manner.
- Staff members have available to them extensive backup services, i.e., interdisciplinary consultation, clerical help, fiscal services, materials and resources for testing, therapy, and instruction. In addition, staff members are usually itinerant, thus consistent follow-up services are easily arranged.

Possible Disadvantages

- Itinerant consultants are not members of the local staff. Thus, who is to supervise the activities of the consultants is often not clear.
- Resource centers are usually urban-based. Often, because the staff members do not live in rural areas, they lack experience with and exposure to American Indian or Alaska Native cultures, language, mores, and value systems.
- Some educational service centers service only the public school systems that financially support them. Thus, their services may

not be available to nonmember agencies.

Local and State Chapters of National Organizations

In many communities, small and large, handicapped preschool children and their families receive excellent support services from local and state chapters of national service organizations as well as from parent and professional organizations. Service organizations include such groups as the Easter Seals Society, United Cerebral Palsy, the Muscular Dystrophy Association and other groups for health-impairments like cystic fibrosis, diabetes and epilepsy. Organizations such as Lions or Elk Clubs pay for glasses and other adaptive appliances and often raise money for special recreation and leisure activities for handicapped children and their families.

Chapters and federations of professional organizations such as the Council for Exceptional Children are active advocates for handicapped preschool children at the local and state levels as are parent chapters of the National Association for Retarded Citizens. Local parent Associations for Retarded Citizens often provide respite and counseling support services for families through their "Pilot Parent Programs." Several parent organizations compile statistics on the needs of handicapped children who live within their community and surrounding areas.

Possible Advantages

- Cost of services provided by these groups is usually covered by community fund-raising, membership fees or donations of needed services. When fees are charged, they are usually minimal and adjusted on a sliding scale.
- Professional and volunteer personnel are dedicated and enthusiastic.
- These organizations are usually experienced in working with preschool children and often specialize in working with this age group.

Possible Disadvantages:

- Service centers are usually located in larger communities/cities, and children often have to be brought to the centers from rural areas.
- Disability Service Centers are usually capable of serving only a small number of children.
- It is difficult to enter into formal cooperative arrangements with some of these types of agencies.
- These agencies may not be experienced with Indian populations.

Individual Consultants

As a result of P.L. 94-142 and the federal requirement that specialized-related services be provided to all children in need of such services, there has been a recent proliferation of private individual consultants that deliver these services. Some of these consultants are highly trained and experienced diagnosticians or therapists with many years of experience with preschool children.

Possible Advantages:

- Minimal time passes between request for services and delivery of services.
- Reliable follow-up services are easily arranged.
- Credentialed consultants are usually highly trained and experienced specialists who can deliver high quality services.

Possible Disadvantages:

- Services are usually expensive.
- Consultants may not have experience working with Native American children since the consultant usually lives and works in metropolitan areas.

- Consultants may not have a reliable clerical and organizational support system.

Information Organizations

Many federal, state, and local agencies provide information concerning disabled and/or handicapped individuals. Some excellent information resources for learning about or acquiring specialized-related services for handicapped preschool children and their families may be found through:

1. Regional Resource Access Projects (RAPS), located in ten national regions and designed to link local Head Start programs with a variety of resources for the handicapped;
2. "Closer Look" -- The National Information Center for the Handicapped;
3. Council for Exceptional Children (CEC) Information Center;
4. ERIC (Educational Research Information Center) Clearinghouse on the Handicapped and Gifted; and,
5. National, state and local "Hotlines for the Handicapped."

For more information on these agencies, refer to Appendix C.

IMPLEMENTING SPECIALIZED-RELATED SERVICES

As discussed earlier, there is a critical need to develop means for delivering specialized-related services to American Indian and Alaska Native handicapped preschool children because of a continuing and alarming shortage of experienced professional personnel. Because of this shortage and because almost all local agencies serving handicapped youngsters have a vested interest in acquiring specialized-related services, cooperative interagency efforts are essential to coordinate the acquisition and utilization of resources which can deliver these services.

The Need for Improved Interagency Coordination

The need for improved cooperative agency interaction in the provision of specialized-related services may best be understood by continuing the tale of Bird Song, our composite Native American child introduced earlier in this chapter:

> It was originally thought, based on comprehensive screening completed at the Head Start Center, that in addition to severe visual problems, Bird Song may have had a hearing problem. Bird Song did not pass the hearing screening test, scored poorly on a speech and language screening instrument and was observed to be limitedly responsive to the questions, comments and requests of other children and classroom staff alike. Head Start contact with the local IHS Clinic indicated that this child had been followed for severe and chronic ear infections in infancy and at various stages along the way. An audiological assessment completed two years earlier at the clinic revealed a mild receptive hearing problem thought to be attributed to the severity of Bird Song's ear infections. A reevaluation of Bird Song's hearing, scheduled with great difficulty by the Head Start program at the local clinic, revealed that this child's hearing was indeed within normal limits. Based on this information, parent input and classroom observations, it was agreed by all concerned that a formal speech and language evaluation was necessary.
>
> The Head Start program then began its attempts to acquire formal speech and language assessment services. Its contact with local BIA school personnel proved fruitless due to the recent loss of their one and only speech clinician. A speech pathologist, previously available to the Head Start program on an individual consultant basis, was contacted but had moved some distance from the area and was "unavailable." Several weeks passed before another qualified speech and language practitioner, in another distant town, was located who agreed to complete a routine examination at a substantial fee. This specialist determined that Bird Song's language competency and processing abilities were significantly delayed and expressed concern about this child's overall performance. It was unanimously agreed that a formal psychological evaluation should be obtained.
>
> After much "shopping" by the Head Start program for a qualified psychologist experienced in working with young children, referral was made to a regional Child Health Project for this service in a metropolitan area ninety miles away. While recommendations were made by the psychologist which translated her findings into intervention strategies for Bird Song, the suggested activities to be implemented at the preschool program and at home appeared initially confusing to the individuals responsible for their implementation. On-site follow-up training experiences were not available through the Child Health Project.

> A formal recommendation regarding counseling support services for this family was made to Bird Song's mother by the psychologist and was also included in the report. Specific concerns were expressed about the inability of the family to communicate effectively with the deaf father which was proving to be an increasingly frustrating and derisive experience for all. The suggestion that Bird Song's family might benefit from instruction in formal sign language was shared with the local Social Services agency and a search begun for a counselor, experienced with the deaf and fluent in manual communication. A counselor was found, 150 miles away, and initial steps have been taken to provide self-instructional materials to this family with which basic manual communication skills can be developed by them.

The Head Start program subsequently developed an individualized education program for Bird Song. It has wrestled constantly, however, with coordinating the resources necessary for the kinds of specialized follow-up treatment services Bird Song requires as well as for appropriate training experiences that will enhance the daily lives of this child, this family, and the dedicated preschool staff who work with them.

Interagency Agreements or "Let's Make a Deal"

Collaborative interagency efforts for obtaining and delivering specialized-related services to handicapped children require time and energy. The willingness of agencies to share information, to agree on common goals and objectives, and to reach agreements about who does what for whom and when, however, can and does result in greater gains for everyone concerned.

After provider agencies for specialized-related services are carefully identified by local education program planners, the type of interagency agreement needed to ensure delivery of these services in a timely manner must be defined. Four primary types of service agreements are most commonly used. They are contracts, memoranda of agreement, formal cooperative service agreements (service consortiums), and informal agreements. A discussion of interagency agreements follows.

1. Contracts. Contracts, being formal, legal documents are legally binding agreements. The responsibilities of the service provider are clearly defined. Generally, contracts are written for rather long-term service arrangements that may be so complex that it is necessary to specify in writing all the terms inherent in the agreement. (See Appendix D for an example.)

Advantages:

- Rights and responsibilities are lucidly outlined and formally agreed upon by a negotiation process.
- Costs are clearly stated and understood.
- There are intrinsic self-protection mechanisms in a legally binding agreement.
- Contracts ensure the durability of the cooperative relationship at least through the duration of the contract.

Disadvantages:

- Contracts can be difficult and expensive to develop. Often legal advice is necessary.
- Contracts impose long-term relationships upon agencies that may want to alter or terminate the relationships before the contract duration.
- Contracts can impose rigidity and inflexibility upon the delivery of related services and not allow for changing conditions.
- Contracts can be broken therefore inviting costly litigation.

2. Memoranda of Agreement (MOA's). These represent by far the easiest method of fostering interagency coordination. (See Appendix E for a sample.) Where there is jurisdictional overlap or confusion, MOA's can clarify interagency roles and responsibilities.

Advantages:

- MOA's act as a catalytic agent in developing interagency understanding and cooperation.
- MOA's are informal and nonbinding, and they allow for flexibility, modification, and changes not possible in a formal contractual arrangement.
- MOA's do not require the many "levels of approval" a contract may have to pass. They can be entered into by two local agencies ensuring rapid delivery of services to children.
- MOA's are easy to write and easily communicate to professional and nonprofessional alike.

Disadvantages:

- Because they are not legally binding, they can be terminated by one or both parties thereby disrupting or ending provision of related services.
- Because they are informal, there can be limited administrative enforcement of MOA provisions by one or both parties thereby fostering loss of agency credibility.
- MOA's require a high degree of trust and existing cooperation between agencies to be effective. Historical mistrust between agencies interferes with the MOA development and follow-through process.
- Because MOA's are often not written by legally trained individuals, they can be ambiguous and lead to miscommunication.

3. Cooperative Service Agreement. A little used, but nevertheless powerful way to initiate interagency coordination is to form multiagency service agreements. One of the major reasons American Indian and Alaska Native preschool handicapped children do not get related services is because of jurisdictional overlaps. It simply is not clear who or what

agency is responsible for providing these services. Thus, nobody provides the service or there is service overkill.

One way to overcome this program "anarchy" is to enter into quasi-official interagency cooperative service agreements via the formation of service co-ops. To form these cooperatives, the line administrators form various service provider agencies form an informal alliance and in effect agree to pool resources and distribute them to children in an organized and cooperative manner. As unrealistic as this may sound, this very thing has been done in many locations. No written agreements are entered into, but there are regular meetings of agency heads to facilitate the ongoing distribution of related services.

Advantages:

- Encourages multiagency communication and cooperation.
- Allows for maximum utilization of limited fiscal human resources by minimizing duplication of services.
- Because these agreements are informal, the parties are not legally bound to participate and thus can branch off and develop local capabilities as resources allow.
- Multidisciplinary approaches fostered by consortium agreements allow for a greater variety of services to handicapped children. Medicine, education and social services, for example, work together to meet the needs of the total child.

Disadvantages:

- Because consortium agreements are informal, they can be broken and thereby interrupt services to children.
- They are difficult to enter into as long as agencies prefer to work independently of one another. They require a great deal of desire on the part of agencies to work cooperatively.

- Service consortiums need a common supervisor, someone to hold the group together and provide motivation and leadership. This responsibility usually falls on one of the member agency administrators and constitutes a certain demand on that person and agency. Thus, ensuring leadership can be difficult.
- Service consortiums are vulnerable to the negative side effects of staff turnover. If replacement administrative staff do not agree with the consortium concept, that consortium can suffer the loss of valuable agency members.

4. Informal Agreements. Informal interagency agreements are often used when two or more agencies want to work together to solve a common local service delay problem. These "under-the-table" agreements usually involve a trade off of services. These agreements are usually not in writing -- but they can be. When there is a broad base of planning input from field staff, parents and others, informal agreements can be very useful in securing related services for children.

Advantages:

- They are easy to enter into and to terminate. They are nonbinding and, therefore, allow for flexibility and freedom.
- They tend to support overall interagency cooperation.
- Informal agreements are easy to administer. They are usually a good solution to a short-term problem.
- They are easy to implement and can develop services rapidly with a minimum of red tape.

Disadvantages:

- Because they are informal, they cannot ensure continuity of services.
- Because they are quasi-official in nature, they may cause internal

auditing and fiscal problems if not properly planned.

- These agreements tend to be highly personal. If one or more of the parties leave, the agreement can end. Thus, they can have a short life span.
- They can be difficult to evaluate by the central office staffs of the participating agencies.

An Example of Cooperative Agency Interaction

It is evident to almost all persons who work with American Indian and Alaska Native children that there is a considerable degree of interagency overlap in the provision of services to handicapped children. This is a nation-wide phenomenon. In many areas of the country, considerable gains have been made in recent years to overcome the problems caused by jurisdictional overlap. In the final analysis, the only way in which coordinated special education services will be administered to these children is if agencies consolidate resources and coordinate their activities with one another. An example of a program where multiple agencies were able to form an informal cooperative service alliance, thereby assuring integrated specialized-related services for chronically handicapped children, is contained in Appendix F of this book.

CONCLUSION

The delivery of educational and specialized-related support services to preschool exceptional children is in the process of unprecedented change. Perhaps one of the most controversial challenges at this time is to extend the scope and accessibility of specialized identification, assessment and treatment services to this population. Efforts to this effect are becoming highly visible in local, state, and federal health and education programs serving American Indian and Alaska Native preschool children. Indeed, the advances toward increased and earlier specialized services are overdue.

The intent as well as the letter of the law contained in the provisions of the "Education for All Handicapped Children Act" and other enabling legislation at the federal and state levels is lofty and innovative. However, reactions from all segments of the professional and lay community bear testimony to the fact that the complexities and variations of state and tribal governments on the one hand and the broad, multifaceted nature of delivering comprehensive specialized-related services to handicapped preschool children on the other hand, make the implementation of these provisions a difficult and controversial task.

Without public awareness of the problems, interagency cooperation, and a conscious effort to overcome the many factors interfering with the delivery of specialized-related services, these services will continue to elude the preschool handicapped American Indian and Alaska Native child.

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CHAPTER 6

Selected Programming Alternatives for Serving Young Handicapped Children by

David H. Ridgley, II

INTRODUCTION

What can be done to serve effectively and efficiently the needs of identified young American Indian or Alaska Native exceptional children on an ongoing basis? Where do I look for successful program practices? Can I go and visit some? Are these practices adaptable or replicable in my locale? Who can or will help me?

These are familiar questions to many preschool directors and administrators who are serving or are planning to serve special populations in geographically isolated communities throughout the country. What they need is access to information about programming alternatives that will address their particular set of circumstances (children's age level and cultural background, geographic location, available funding, available resources, handicapping conditions, etc.) and at the same time speed the best services to the local clients.

Fortunately, help is available through major federal legislation like P.L. 94-142, P.L. 93-221 (Sec. 504) and P.L. 95-568 (The Economic Opportunity Act which provides for special handicapped services to Indian and Migrant Head Start children). These Acts along with other programs such as the Department of Education's Handicapped Children's Early Education Program have provided funding to literally hundreds of innovative experimental programs for young handicapped children (birth to eight years) and their families. As a result of these experiences, a wealth of history and practice has evolved through the years so that a sort of "shopping-market" of specially developed programming alternatives for serving handicapped children has emerged. The market usually includes two categories: (1) Demonstration projects are ones that have developed and demonstrated exemplary methods or models for solving or ameliorating significant educational problems while (2) Outreach projects have established other efforts to offer their procedures -- in whole or in part -- to clients in their own community whom they are unable to handle and to similarly affected populations in other communities. Either one or both types of these programs develop and distribute information on their methods. Either can be of service to you, if you make contact with them.

You might think that locating the programs with procedures that will be helpful to you will be a major problem. Put that out of your mind! The "Supermarket" of program alternatives is well stocked. It's overstocked! The problem is maneuvering through the aisles and "brand" names to find the shelves with the most suitable quality models, components or programs for your own situation or circumstances.

This chapter is designed to help you get acquainted with the variety of available, useful, and appropriate program alternatives from the special education "supermarket." I will present alternatives for Native American and Alaska Native preschool children who have been professionally diagnosed as handicapped or are suspected of being handicapped.

Twenty-one different program models and components presently being used to serve young handicapped children, or adaptable for them, will be highlighted. In the author's view and based on his experience, most are easily adaptable in part or in whole to similarly situated programs. A Basic Characteristic Matrix (p. 129) is offered as a guide to help decision-makers consider the program alternative(s) which might be best suited to their special situation; it appears at the end of this chapter.

ALTERNATIVE PROGRAMMING MODELS FOR SERVING HANDICAPPED PRESCHOOLERS

The following list includes twenty-one alternative model programs that can be adapted or replicated by leadership personnel planning to serve young handicapped children. These models were selected based upon the author's experience of having worked with numerous communities and preschool programs across the country. Each annotation is organized by (a) description, (b) recommendations and (c) program contact information. The program addresses have been included for two purposes: (1) to provide you with information on whom to contact and (2) to assure that credit is given to the project responsible for the development of the model and its implementation.

Chapel Hill Training Outreach Project (1)

Description. This ten-year-old diagnostic/prescriptive approach developed under the direction of Ann Sanford includes an extensive assessment instrument: The Diagnostic Learning Accomplishment Profile (D-LAP). Staff must be trained to implement the recording schema. In addition to the D-LAP, a short form has been developed and is more appropriate for use with large numbers of children.

Individual learning objectives can be established for children through use of the LAP and a parental needs assessment. The Chapel Hill model is used in a variety of service delivery systems: center-based, home-based, resource room, and mainstream settings. Teacher training in task analysis, behavior modification, and parent involvement are basic model components, in addition to the assessment-curriculum design.

The Chapel Hill Training Outreach Project provides a large number of project-developed training and awareness materials. Slide-tape programs, public service announcements, manuals, and a variety of print materials are available which cover topics such as assessment, curriculum, family involvement, P.L. 94-142, and competency-based training. A comprehensive listing of materials is available from the project.

Recommendations. The major efforts of this project are directed towards replication of the LAP model. Since a significant number of both Indian and Migrant Head Start programs are already using it (varied implementations), any American Indian or Alaska Native preschool program in search of alternative programs and curricula for handicapped youth (three to five years) should consider this model for adaptation or replication.

Since the D-LAP is so extensive, it should be used (in Head Start) only for specific handicapped children in order to define more clearly their specific needs. The shortened form can be used for all children. This project is center-based, but its materials could easily be used in a home-based program.

Contact Information

Address: Lincoln Center
Merritt Mill Road
Chapel Hill, North Carolina 27514

Phone: 919/967-8295

The Portage Project (2)

Description. The Portage Parent Training Project is a ten-year-old, home-teaching, parent-involvement program for handicapped children in rural settings, aged birth to six years. It provides a systematic method for training parents in appropriate teaching and child management techniques. The materials developed by the project include:

- Developmental Sequence Checklist -- which covers the areas of self-help, cognitive, socialization, language and motor skills development.

- Curriculum Card File -- which is five sets of color-coded cards corresponding to each developmental area on the checklist and containing specific home-based activities.

The activities in the file are designed to ensure measurable achievement on a short-term basis. They are activities to be carried out primarily in a home setting. (The Portage Project has combined a home-based model with a precision teaching model.) The administration of the checklist and ongoing documentation (weekly progress report, behavior evaluation log) requires staff training.

The project provides three major types of training: (1) training and technical assistance to sites implementing all or a significant part of the Portage Project Model, (2) one- to three-day workshops on selected topics or components of the model, and (3) three-and-one-half day on-site workshops in Portage, Wisconsin. The project also conducts awareness workshops.

The following materials are available through contact with the Portage office:

- Portage Guide to Early Education, a developmental curriculum for use with children either handicapped or normal.
- Portage Parent Program, designed to teach systematically appropriate teaching and child management techniques.
- Portage Guide to Home Teaching, a system through which parents are taught how to teach their own children.

Recommendations. These materials are designed for home-based intervention and parent training but can be adapted for use in a center-based program. Intensive preservice and inservice training is necessary prior to implementation. Materials have been successfully used with minority populations including American Indians.

Contact Information

Address: 412 East Slifer Street
P.O. Box 564
Portage, Wisconsin 53901

Phone: 608/742-5342

Project Memphis (3)

Description. Project Memphis, developed at Memphis State University in the early 1970's, is a commercially produced, ongoing early childhood remediation program helping handicapped children from birth to five years. The Project has developed a set of materials for helping special educators set up early childhood remediation programs based on the Memphis model. The materials consist of:

- Project Memphis -- Enhancing Developmental Progress in Preschool Exceptional Children -- which explains the goals of the program and how to set up a similar program.
- Assessment materials -- which include a comprehensive developmental scale, and a developmental skills format for recording the skills a child is working on and for recording skill development gains.

The forms are used sequentially with each child in the program. The "Developmental Scale" is used to determine skill deficits. The "Developmental Skill Assignment Record" is a detailed account of the skills in which the child will receive training and encouragement in order to bring him to an appropriate developmental level. The record is continuous. It indicates progress. And it prescribes skills to be taught.

A curriculum guide entitled, Lesson Plans for Enhancing Preschool Development Progress: Project Memphis is also available. This guide provides an adaptation appropriate for use at a regular center-based program for handicapped and/or nonhandicapped children. Fearon, the publisher, will provide technical assistance and training to interested consumers who wish to use the new Lesson Plans. Any request must be supported by a serious interest in using the model and materials.

The Memphis project may intervene with a child, after assessment, at one of five levels:

Level 0	No services are necessary.
Level I	The child is referred to community resources and followed up by the project.
Level II	The child is referred to a community service, with the project providing monthly or biweekly tracking and a home-based program.
Level III	Direct project services are given to the parent and child through a home- or center-based program, concurrent with placement in another program.
Level IV	The child receives only project services.

Developmental gains are measured by the project before and after intervention with norm-referenced (Bayley) and criterion-referenced instruments (Portage, LAP-D, Brigance Diagnostic Inventory).

The Training for Trainers Manual provides specific strategies for helping preschool Head Start teachers to implement this model of services. Extensive inservice staff training is needed.

Recommendations. This project is worth investigation -- especially by rural preschool projects, like those found in Alaskan and American Indian communities, that are contemplating replicating alternative models. Programs seeking new and innovative alternative models should investigate these materials for practical replication.

Contact Information.

Project Memphis materials available from:

Address: Fearon Publishers
6 Davis Drive
Belmont, California 94002

Phone: 415/592-7810

Lesson Plans for Enhancing Preschool Developmental Progress are available from:

Address: Kendall/Hunt Publishing Company
2460 Jeroer Boulevard
Dubuque, Iowa 52001

Phone: 319/588-1451

Ochlocknee Project: Working with Children (4)

Description. This outreach project, developed as a demonstration project in the early 1970s, has a curriculum consisting of guidelines and objectives for working with multihandicapped children birth to eight years. The following areas are covered:

- Cognitive development
- Language and communication
- Psycho-motor development
- Social-emotional development
- Self-help skills

The major target groups served by this project include but are not limited to: (1) many children (birth to five) who are high-risk, handicapped, abused-handicapped, or moderately to severely or profoundly handicapped; (2) families of handicapped children, and (3) community human- and child-service agencies. The project maintains a zero-reject policy.

Recommendations. The Ochlocknee project serves a rural community and emphasizes working with families and maximal utilization of community resources. The project is designed for use by center-based programs. Materials are available for any needed staff training. It is recommended that this model be examined for possible use with multihandicapped youngsters in sparsely populated settings.

Contact Information.

Address: P.O. Box 110-A
Ochlocknee, Georgia 31773

Phone: 912/574-5123

Model Preschool Center for Handicapped Children (5)

Description. This ten-year-old project, the Model Preschool, directed by Dr. Alice Hayden, uses a diagnostic-prescriptive/behavioral model in which each child is encouraged to make the best possible progress toward developmental norms. Parents are actively involved in the program. The University of Washington setting for the Center is the Experimental Education Unit, an award-winning school building especially designed for handicapped children. Each child is assessed on several measures quarterly. Direct and daily measurement is used to monitor and, when necessary, change child programs. Two programs of the center have been approved for adoption/adaptation by the USOE Joint Dissemination Review Panel -- the Communication Model and the Program for Down's Syndrome and other Developmentally Delayed Children. Outreach trainers, with written materials developed at the center, provide instruction and technical assistance to teachers, parents, administrators, support professionals, and others who work with young handicapped children in all parts of this country and in several foreign countries. Training is conducted at the field site, at the demonstration center, in workshops, or in a combination of settings.

Considerable staff training would be necessary to implement all phases of these models. Staff training is often given at the Experimental Unit so that trainees can observe the Model Preschool Center in operation.

Many materials have been developed by the project, including a series of five manuals on integrating handicapped children into Head Start. The manuals outline the major components of the model, which include:

- Communication
- Identification, Assessment, Referral and Follow-up
- Parent Involvement
- Staff Training
- Systematic Integration

These manuals offer guidance for mainstreaming handicapped children. However, they do not contain systematic programming.

Recommendations. This program is center-based. Considerable inservice training would be necessary to replicate the approaches.

Contact Information.

Address: Model Preschool Center for Handicapped Children
Experimental Education Unit
College of Education
Child Development and Mental Retardation Center
University of Washington
Seattle, Washington 98185

Phone: 206/543-4011

Family Education Program for Preschool Hearing Impaired Children (6)

Description. "The Guidelines for a Family Education Program for Preschool Hearing-Impaired Children" developed by this project outline a rural program which assists families with hearing-impaired children. The Guide contains:

- Program Objectives
- Plans for Staff and Physical Facilities
- Identification and Planning Requirements
- A Demonstration Home Week Program Guide
- Outlines of Discussions with Parents
- Plans for Home Visits
- A Family Education Aide Program

The program works with parents on a one-to-one basis in their homes and through parent group discussions at central locations. It is limited to working with families of hearing-impaired children. The model could be adapted to other impairments by using the same approach and substituting appropriate content.

Recommendations. This model is highly recommended for programs that serve a large number of Alaskan or Indian preschoolers. It is home-based and designed for those working directly with parents. It was designed for a rural program.

Contact Information.

Address: Alaska Treatment Center for Crippled Children and Adults, Inc.
3710 East 20th Avenue
Anchorage, Alaska 99504

Phone: 907/272-0586

Multi-Agency Preschool Outreach Project (7)

Description. This six-year-old, former demonstration project has a home-based program for handicapped children aged birth to three years and a community-based program for three to five year olds. It is an Affiliated Exceptional Child Center administered by Utah State University. The major objectives of the project's outreach component are to:

1. Provide outreach assistance to projects in the Utah Consortium of Preschool Programs, Nevada Division of Mental Retardation, Community Training Centers in southern Idaho and New Mexico, Office of Navajo Economic Opportunity Head Start Centers, and therapeutic day center in Tuba City.
2. Provide training workshops.
3. Train key personnel at project sites in the use of the model and the CAMS curriculum.
4. Collect and analyze data related to outreach effectiveness.
5. Continue development of a cognitive package.

The basis of the intervention is a curriculum and monitoring system (CAMS) developed by the project in five developmental areas. The program utilizes (1) parents of preschool handicapped children as intervention agents by providing them with the CAMS curriculum, and (2) existing community preschool and day care services to mainstream young handicapped children (three to five years) by providing CAMS materials and training parents and teachers. Measures of child progress include: Bayley, VMI, PPVT, Boehm Concept Development, Assessment of Children's Language Comprehension, and criterion tests in the five developmental areas (May and Meyer, 1980). This project has been approved for adoption and dissemination by the U.S. Joint Dissemination Review Panel.

Recommendations. This procedure appears to be a sound alternative for rural programs that are serving special populations. Considerable analysis by program staff is suggested before committing yourself to replication of this project model or its components since considerable intensive training followed by both ongoing inservice and preservice training will be mandatory. Programs might even consider adapting one or more components of the model as opposed to attempting a full replication.

Contact Information.

Address: UMC 68
Utah State University
Logan, Utah 84322

Phone: 801/752-4100, ext. 8273

Project TEACH (8)

Description. This three-year-old demonstration project, directed by Nancy Hoyt, serves developmentally high-risk children from birth to three years of age. The general casefinding procedure is a referral by parents or professionals.

Two- and three-year-old children are served in the preschool two to four days per week, or at home on a weekly basis. Children from isolated bush villages are seen in their homes once or twice monthly. The Portage-based curriculum is individualized to promote optimal growth in the areas of language, motor, social, self-help, and cognitive development. Children are given complete evaluation at six-month intervals. Remedial objectives are initially determined by the intensive baseline evaluation.

The Alpern-Boll is used initially and at six-month intervals. The

Oliver Environmental Language Intervention Program is administered by a speech pathologist.

Staff receives inservice and specialized training as the need and opportunity arise. Weekly meetings bring the staff together to discuss and review individual cases, with emphasis on the team approach. (See May and Meyer, 1980.)

Recommendations. This project model might be especially appealing for Native American and Alaska Native programs because of its emphasis upon parent training and its unique adaptation of other programs' components, materials and assessment instrumentation.

Parent training is an essential component of the program. The therapist/teacher's role is to educate the child through the parents. Assessing the development of parents as effective teachers is accomplished (1) indirectly through the child's progress, and (2) directly through the Portage Project method of parent assignments. That is, a parent is designated to promote communication among parents involved in the project. Parents provide feedback on their experiences by completing a parent program evaluation questionnaire.

This model should lend itself well to the needs of programs located and servicing children in rural geographic areas.

Contact Information.

Address: 1020 Barnette
Fairbanks, Alaska 99701

Phone: 907/456-2640

Bismarck Early Childhood Education Program (BECEP) (9)

Description. This three-year-old demonstration program is directed by Dale Walker and serves children with marked developmental barriers, as assessed on the BECEP Assessment Tool. Twenty-four children, ages birth to three years are served in Bismarck, twelve children are served in a satellite classroom in rural North Dakota, and six children are served on the Standing Rock Indian Reservation.

A combination center- and home-based program is used. Each child is scheduled for one-and-one-half hour class sessions twice per week. Teachers make home visits once every two weeks. Each child has an individual program which is updated at least twice per year. Ancillary services are provided by a school psychologist, physical therapist, occupational therapist, speech therapist, and vision and hearing specialists.

The BECEP Assessment Tool is administered at the beginning and end of the program year. The Bayley Scales are also given upon program entry. Continual child progress is monitored on the BECEP Curriculum Guides. The child is videotaped within a group at the beginning and end of the year for comparison ratings. At the end of the year the percentage of each child's long- and short-term IEP objectives that have been met are determined.

A parent or guardian attends each session with the child. Parents are responsible for completing in-class and home tasks assigned by the teacher. Parents are rated biannually on the ABC (Assessment Behaviors of Caregivers) Scale and parent/child videotapes. IEPs are written for each parent, based on needs identified on the Parent Needs Assessment, the Q-Sort, and by the parent.

Weekly staff meetings are held for BECEP staff. IEPs are written for each teacher, based on ratings from the Teacher Competency Scale and needs identified by each teacher. The teachers are rated biannually on the ABC Scale and teacher/child videotapes. Training packets are available for each new staff member, and ongoing training is obtained through monthly

BECEP inservice.

BECEP consists of five early childhood programs under a common administration: Head Start, Day Care, Special Needs Program, Child Family Resources Program, and the Early Intervention Program. (Refer to May and Meyer, 1980.)

Recommendations. This program model's combination structure (home-/center-based) makes its strategy particularly adaptable as an alternative for potential projects located in geographically isolated communities. Its various models are considered by many special educators to be exemplary.

Contact Information.

Address: 900 East Bowen Avenue
Bismarck, North Dakota 58501

Phone: 701/255-3866

Acoma Early Intervention Project (10)

Description. This three-year-old demonstration program serves children aged birth to five years. Nine handicapped children are served, with various handicapping conditions such as Down's syndrome, Lowe's syndrome, hydrocephaly and cerebral palsy. All Acoma handicapped children from birth to five years of age are served in the Acoma Early Intervention Project.

Children are served in center-based or home-based programs or both. Opportunities for mainstreaming exist in the day care centers. Keresan, the Acoma language, is used in providing educational services. Data are taken on a daily basis by using anecdotal and charting procedures. The LAP is used for development of IEPs, along with parent and staff input.

The Portage Project checklist is used on an ongoing basis. The Alpern-Boll is administered on an annual basis. Psycho-educational evaluations are completed on each child on an annual basis.

The parents participate in the delivery of services by providing input relative to their child's educational program. Input from parents helps to determine the type of information and training they wish to receive. The parent group meets at least once a month. Two parents serve as Advisory Council members.

Inservice training is provided on an ongoing basis to the professional and paraprofessional staff by the associate director of education and the special education teacher. Staff members also participate in training institutes and conferences to augment their skills in working with handicapped children. Consultants are also an integral part of training. For the past two years, the Pueblo of Acoma and the Pueblo of Laguna have coordinated efforts to get a special education class taught on-site at Acoma through efforts from the All Indian Pueblo Council Teacher Education Project and the University of New Mexico Special Education Department. The paraprofessional staff will enroll in the special education class. (Refer to May and Meyer, 1980.)

Recommendations. Programs located in rural settings and programs serving predominantly Indian populations might find this project's methods for serving handicapped children worth closer investigation. The fact that this program has adapted well-known materials and assessment instruments to address the needs of its handicapped preschoolers should make its applications of those materials particularly appealing to other similarly affected programs seeking alternatives.

Contact Information.

Address: Box 307
Pueblo of Acoma, New Mexico 87034

Phone: 505/552-6621

Circle Preschool (11)

Description. This project, developed in the early 1970s, has an assessment and programming model for classrooms with mainstreamed handicapped children. Their materials, which follow, outline the phases of the program:

- Live Oak Curriculum (organized into nine program areas: for example -- language arts materials, music, etc.)
- Classroom Screening Instrument
- Individual Assessment
- Classroom Screening
- Parent Program Handbook
- Inservice Handbook

The phases correspond with most of the Head Start components and have been geared for a mainstreamed classroom setting.

Recommendations. The materials are most appropriate for a center-based (perhaps urban) program with a limited budget. The staff training manual could be useful for inservice training sessions.

Contact Information.

Address: Circle Preschool
9 Lake Avenue
Piedmont, California 94611

Phone: 415/658-8323

People's Regional Opportunity Program (PROP) -- Maine Model (12)

Description. PROP serves 130 three- to five-year-old Head Start children. During fiscal 1980, twenty percent of the children were found to be handicapped. The populations served included Native Americans and seasonal farm workers. The program developed its own Developmental Assessment Form (DAF) which covers the following areas:

- Gross Motor
- Fine Motor-Perceptual
- Language
- Cognitive
- Social-Emotional
- Self-help

On the basis of the DAF, teachers plan daily and weekly prescriptive activities. PROP is slated to be reopened this summer (1980) and will include a special curriculum. The program uses curriculum materials from the LAP and School Before Six. A program for staff has been developed and is ongoing. Outreach activities to find handicapped children are carried out by Family Service Workers.

Recommendations. This model could be used with mainstreamed children in a center-based program. However, extensive training is necessary for implementation and as yet no training manual has been made available for this purpose. Since the project services a large number of Indians and farm workers, it is worth a closer look by Native American and Alaska Native programs. It has also employed some very unique strategies for utilizing community resources. Information and the DAF are available from the program.

Contact Information.

Address: People's Regional Opportunity Program
24 Pleasant Street
South Portland, Maine 04106

Phone: 607/547-4251/0

The Cooperstown Model (13)

Description. This model, directed by Jane Deer, provides specific procedures in a step-by-step format for working with the child with special needs in a Head Start classroom. Videotaping is an integral part of the project.

In addition, a Mobile Resource Center is used. Materials include information on:

- Advocacy
- Parents of Children with Special Needs
- Program Development for Children with Special Needs
- Resource Materials
- Specific Handicapping Conditions

Recommendations. This project relies heavily on videotaping procedures and the use of a child services specialist. Therefore, expensive equipment and a well-trained staff must be available in order to implement it effectively.

Contact Information.

Address: Head Start in Otsego County
Opportunities for Otsego, Inc.
193 Main Street
Cooperstown, New York 13326

Phone: 405/964-2251

Homestart Project -- Kickapoo Tribe of Oklahoma (14)

Description. This project, directed by Ms. Sherri Caiter-North, provides a home-based early intervention program for children of the Kickapoo Tribe aged birth to eight years. It serves children handicapped by developmental disabilities, developmental delays and learning disabilities. It emphasizes that parents are an integral part of the program. Parents receive training in the following areas:

- Socialization skills
- Communication skills
- Fine and gross motor development
- Perceptual abilities

Recommendations. This program could be adapted to home-based preschool programs and also serve mainstreamed children. Detailed information on the materials developed by this project is not currently available.

Contact Information.

Address: Homestart Project
Kickapoo Tribe of Oklahoma
Early Childhood Development
P.O. Box 58
McCloud, Oklahoma 74851

Phone: 405/964-2251

Educational Reform Through Parent Involvement and Special Needs Project (15)

Description. This project is run by the Ramah Navajo School Board. It seeks to identify and meet unfulfilled needs of exceptional children and to increase the degree of parent involvement. Exceptional Navajo children are served through a range of diagnostic and instructional services, group screening, and individual assessments. Parents are involved through a parent/teacher resource room staffed by parents who give students instruction in Native American skills. In the preschool setting, staff and parents work side by side. Language development and cognitive skills receive considerable emphasis.

Recommendations. This project serves children preschool to Grade 12. Components of the preschool program are adaptable for a center-based program to improve the services rendered to mainstreamed handicapped children.

Contact Information.

Address: Educational Reform Through Parent Involvement
and Special Needs Project
Ramah Navajo School Board
Educational Division
P.O. Box 248
Ramah, New Mexico 87321

Phone: 505/783-5821 ext. 266

Project Palatisha (16)

Description. This is a preschool program for handicapped Indian children on the Yakima Indian Reservation in Washington. The model is complemented by an intensive five-day special education training model. The training is available to preschool administrators, teachers and other support staff (including parents and volunteers).

The focal point of the Palatisha model is its Developmental Checklist, which is a developmentally-sequenced instrument. It is useful in identifying "high-risk" preschool children who require further evaluation. It is also used as a prescriptive device for providing individualized educational services.

The checklist is a selected collection of many assessment measures commonly used in the areas of Cognition, Fine-Motor, Gross-Motor, Language, and Self-Help. It is valuable in helping teachers plan activities that are geared to the special needs and abilities of each child.

The training component of the model encompasses a one-week workshop, a practicum and a follow-up at the trainee's work-site. The training is more practical than theoretical. Over the period of the week, the participants are expected to demonstrate and achieve a score of ninety percent accuracy in six specific areas: (1) developmental assessment, (2) behavioral terms, (3) individual program preparation, (4) collection of baseline and ongoing program data, (5) updating individual programs, and (6) administering individual programs. If the participant completes the training and follow-up activities satisfactorily, he will become eligible for three undergraduate/graduate credits.

Recommendations. The Checklist is recommended for use by programs that serve minority, multiculture and bilingual preschool children. The Checklist should be administered in the child's language if the child is monolingual. If the child is bilingual, the Checklist should be administered in both languages or the dominant language. The Checklist should be used in conjunction with other methods when used as a basis for referral. It should not be used to label a child as handicapped.

The Palatisha Model is appropriate for both center and home use. It is complemented by a manual which covers: (1) Developmental Assessment, (2) Behavior, (3) Speech and Language, (4) Hearing, (5) Working with Families, (6) Mainstreaming, and (7) Handicapping Conditions.

Contact Information.

Address: Yakima Indian Nation
Division of Education
Special Projects
P.O. Box 151
Toppenish, Washington 98948

Phone: 509/865-5121

Saturday-School: Parent-Child Education Program (17)

Description. The Saturday-School is one of the U.S. Office of Education's national diffusion network "developer-demonstration" programs. It is a school-centered and home-based learning program for four-year-olds with special problems and handicaps.

Four-year-old children are involved in a three-hour Saturday-School complemented by weekly home teaching visits. Emphasis is placed upon early identification and treatment of problems. All children are thoroughly tested. Follow-through is provided as prescribed by the appropriate consultants and/or diagnostic/prescriptive teacher-specialists.

Parent involvement is highly stressed both at home and in school. The project is unique in that parents conduct small-group instructional periods at school on Saturdays, provide informal learning experiences at home, and participate in home-teaching visits. The school provides weekly "Home Activity Guides" to aid parents in developing ideas for at-home learning activities.

Bibliographic and other child development resource materials can be obtained from the project.

Recommendations. This project model will lend itself well to rural settings. Its Saturday-School and weekly home-teaching component makes it ideal for mainstreaming young, handicapped Indian or Alaskan children on isolated reservations

Contact Information.

Address: Ferguson Reorganized School District
655 January Avenue
Ferguson, Missouri 63135

Phone: 314/521-2000

Dad: The Insignificant Parent? (18)

Description. "Dad: The Insignificant Parent?" is sponsored by the Parents Education Bureau of Hingham, Mass. It consists of a twenty-minute cassette tape accompanied by a twenty-four page guidebook. The cassette is designed as a working guide for parents and teachers who are looking for a program to explain learning disabilities and set up ongoing plans so that fathers can be involved in the developmental process with their learning-disabled children.

The project began in 1975. By the end of 1977, it had trained 300 participants

Recommendations. "Dad" is ideal for programs that need to get fathers involved in the mainstreaming of handicapped children. The model is quite appropriate for training people who work with fathers. Since there is no training prerequisite, the model lends itself well to work with paraprofessionals and laymen. "Dad" comes highly recommended for increasing parent involvement with severely/profoundly handicapped children and boosting parent advocacy.

Contact Information.

Address: Parent Education Bureau
4 Camelot Drive
Hingham, Massachusetts 02343

Phone: 617/749-2097

Project PEECH (19)

Description. Precise Early Education for Children with Handicaps is a ten-year-old outreach program directed by Merle B. Karnes of the University of Illinois. It is a center-based program for three- to five-year-old handicapped children and their families. Although the primary population is the mild to moderately handicapped, the program's procedures have been adapted for lower functioning sensory-impaired children. In addition to pre- and posttest data which are obtained on all children, teachers assess each child's abilities, set individualized goals and objectives, teach, and continually evaluate child progress.

The major PEECH objectives are:

1. To train site personnel in the procedures for developing, implementing, and demonstrating a model early education program for preschool handicapped children.
2. To prepare and disseminate materials to assist early childhood personnel in the education of handicapped children.

In addition to the intensive training which is provided to each year's replication sites, PEECH annually conducts an average of forty-five component workshops on topics relevant to early childhood special education and an average of fifteen awareness workshops. Over 8,000 materials are mailed to interested professionals throughout the United States. People from every state and several foreign countries visit the demonstration site each year. Finally, PEECH has Joint Dissemination and Review Panel (JDRP) approval for dissemination.

Recommendations. Extensive staff training will be necessary if a program cares to replicate the PEECH Model. However, many component materials are available and adaptable to special population Head Start programs in rural geographic settings. Interested programs should contact either of the PEECH projects two replication specialists for detailed information.

Contact Information.

Address: University of Illinois
Colonel Wolfe School
403 East Healey
Champaign, Illinois 61820

Phone: 217/333-4890

Project LEEP (20)

Description. This three-year-old, home- and center-based program is directed by Larry Goldsmith. Children birth to five years of age are eligible regardless of severity or multiplicity of handicaps -- except deaf and deaf/blind three- to five-year-olds who are served in regional or state programs.

Center- and home-based delivery systems are employed for three- to five-year-old children, the choice of which is determined by several criteria. Services for birth to two-year-olds are home-based, supplemented by center-based parent-child activities. Speech and language services are provided in the home via a consultative model and in the center via direct therapy and coordinated teacher/clinician programming. The CAP System, with behavioral objectives in five developmental areas, forms the basis of the curriculum. The PEECH Model provides the framework for classroom instruction.

Within thirty days of placement, the CAP System diagnostic instrument is used. Reassessment occurs as objectives are achieved and at the end of the year. Pre- and postmeasures for three- to five-year-olds include the Stanford-Binet, Vineland, and Preschool Language Scale. Pre- and postmeasures for birth to two-year-olds are Cattell and Vineland. Preschool language delays are pre- and posttested with a battery of tests.

Individualized parent training is provided in assessment, teaching and behavior management skills, child development, and specific handicapping conditions. Parents are involved in diagnostic assessment and program planning.

Parents in the home program serve as the primary teachers for their children. Parents in the center program act as partners with classroom personnel, working at home on specific educational objectives.

Paraprofessionals receive individualized training from their supervising teachers. Staff training includes assessment, teaching, behavior management and parent training skills.

Recommendations. Intensive initial training with ongoing inservice instruction is mandatory if the model is to be of value to your program. Investigation of this model might center around exploring how this program adapted existing model components (PEECH for example) to its needs.

The model is also useful for guiding programs in developing and implementing more effective strategies for obtaining interagency agreements with community resource providers.

Contact Information.

Address: JAMP Diagnostic Center
Route #1
Karnak, Illinois 62956

Phone: 618/634-9568

Early On Program (21)

Description. This six-year-old model program is directed by Dr. Richard Brady and is affiliated with the University of San Diego Foundation. Though now funded primarily as an outreach project, it also functions as a demonstration program. The demonstration model uses a behavioral approach to home- and center-based programming. The basis of the model is performance-determined instruction, using a data-based instructional-management system. Its goals are:

1. To develop exemplary procedures for delivering quality educational programs to young multihandicapped children and their families.
2. To increase the number of severely, profoundly and multiply handicapped children receiving services through the Early On Model.

3 To provide technical assistance, training and materials to agencies currently serving or preparing to serve handicapped children in home- and school-based programs.

Technical assistance and training were provided to educational agencies in California, Head Start, public and private school programs, private institutions and community training homes. Special education students at the university received preservice training.

Recommendations. This program appears to be a good model for programs (particularly Indian or migrant) located in the Southwest to investigate for possible adaptation of selected components and materials -- or for possible replication of the program's model in total.

This program's home- and center-based structure makes it attractive for rural and geographically isolated programs. The "Self-Instruction Modules" and "Early On Forms" may be particularly adaptable to rural settings.

Contact Information.

Address: 5300 Campanile Avenue
San Diego, California 92182

Phone: 714/265-6974

CONCLUSION

Many exemplary program models and alternatives have been specifically developed to serve handicapped preschool children. Many are replicable and adaptable to American Indian and Alaska Native preschool program needs.

Before adopting or adapting existing special education models, resources and alternative curricula for your programs, you should determine the child development and learning theories to which you subscribe. If you are a novice to special education and handicapped children, you should familiarize yourself with some of the basic principles of human development, child development, special education and learning theory before deciding on any special curricula and/or resources to be used with handicapped children in your program. Feel free to consult local specialists, your state department of education early childhood personnel, Head Start trainers, and others who may be able to provide you with a practical "launching pad" for developing and/or clarifying your ideas regarding those principles which will influence your selection of a programming alternative for your locale.

The twenty-one program descriptions presented in this chapter are intentionally brief. They are intended to help program personnel see that a number of programs of similar size, socio-cultural-ethnic complexity, rural/urban geography, and funding level have been both creative and innovative in responding to the needs of handicapped children. (Refer to the Basic Characteristics Matrix in Figure 1 for overview to all programs reviewed. Please note that each program reviewed is referenced by its number, 1-21.)

The closing message for the reader to absorb having gone through this material is that there is no need to reinvent the wheel if you are planning to serve handicapped preschool children. You can both learn and benefit from the successes and mistakes of others who have launched both modest and expansive projects in their efforts to serve handicapped children. By all means feel free to contact any of the programs outlined in this chapter or look for additional information from resource guides such as the Handicapped Children's Early Education Program Overview and Directory (May and Meyer, 1980).

FIGURE 1

BASIC CHARACTERISTICS MATRIX

CATEGORIES:	PROGRAMS BY NUMERICAL ORDER																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
I. Primary Focus:																					
A • home-based		X	X			X	X		X	X				X			X		X	X	X
B • center-based	X			X	X		X	X	X	X	X	X	X		X	X	X			X	X
II. Also Adaptable for:																					
A • home-based	X							X								X					
B • center-based		X	X															X			
III. Scope:																					
A • all handicapped	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X
B • specific handicaps						X												X			
IV. Monetary Investment in materials:																					
A • minimal $0-45			X	X	X	X	KN	X	KN	X	X	X		X	X		X	X	X	X	X
B • moderate $45-95		X														X					
C • high $100 plus	X												X								
V. Materials Available:																					
A • teacher training	X	X	X	X	X	X	X		X		X	X	X	KN	KN	X	X	X	X	X	X
B • child assessment	X	X	X	X			X		X		X	X				X	X		X	X	
C • curriculum	X	X		X			X		X		X					X	X		X	X	X
D • parent training		X	X	X		X	X		X		X					X	X	X	X	X	X
E • other/supplementary	X			X		X		X		X			X			X	X	X	X	X	X
VI. Utilization of program model/Model components:																					
A • Being used for Native Americans	X	X			X		X		X	X				X	X	X			X	X	
B • Being used for Alaskan Natives		X			X	X	KN	X								X					
C • Being used for Migrants	X	X		X	X		X									X			X	X	X
D • Warrants investigation by other programs for possible adaptation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
VII. Training Accomplishments by numbers of people trained:																					
A • 0				X				KN	KN	X	KN	KN	KN	X	KN		KN			KN	
B • to 100						X															X
C • 100 to 200							X												X		
D • 200 to 300																					
E • 300 to 400																					
F • 400 to 500																					
G • over 500	X	X	X		X											X		X			
VIII. Replication Accomplishments by number of sites using the model/model components:																					
A • 0						KN			KN		KN	KN	KN		KN		KN			KN	
B • 1 to 10				X				X		X				X							
C • 10 to 20																					X
D • 20 to 30							X												X		
E • 30 to 40																X					
F • 40 to 50																					
G • 50 to 100		X			X																
H • over 500	X		X															X			
IX. Program/Model type:																					
A • Demonstration				X		X	X	X	X	X		X	X	X	X	X	X			X	X
B • Outreach	X	X			X		X				X					X		X	X		
C • Commercially produced			X																		

* Kn = Unknown

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CHAPTER 7

Designing an Inservice Training Program by
Pascal Louis Trohanis

INTRODUCTION

Because of emerging national and state laws, litigation decisions, new instructional practices, and parent-professional advocacy, inservice and continuing education have become more vital to programs and personnel serving young American Indian and Alaska Native handicapped children and their families. Efforts in inservice education serve a variety of purposes. These include:

- Orienting new staff or families to local early childhood programs
- Upgrading staff competencies for new jobs, roles or responsibilities
- Changing attitudes and expectations of parents and community leaders
- Keeping staff abreast of content changes and new technology in their disciplines
- Sensitizing staff to the Native American's cultural and language heritage
- Nurturing a sense of continuous self-improvement for all staff
- Helping to keep and/or recruit staff
- Improving interdisciplinary functions among staff
- Familiarizing staff, parents, and others with culturally-relevant testing and teaching materials

To fulfill these and related purposes successfully, planners must be aware of three things. First, inservice planning and training activities must deal with early childhood, special education, training, and cultural issues simultaneously. Second, inservice training must be seen as an integral part of any program serving young children with special needs. Third, organization and accountability must guide the planning, development and implementation of inservice programs.

By dealing thoughtfully with these matters planners can avoid criticism which frequently labels inservice endeavors as "ineffective," neglected," or "disjointed." Houston and Friedberg (1979), Wood and Thompson (1980), and others believe that inservice in general has no systematic direction or sequence of experiences aimed toward specified objectives: rather, it is viewed as an occasional enterprise. Others complain about inservice training which involves American Indian and Alaska Native educational issues. For example, Zimiles (1976) and collaborators reported on training gaps in both the Bureau of Indian Affairs and the public schools they visited. They observed: "Few teachers have had any training in the history and customs of the tribe whose children they are teaching. As a result, most Bureau and public school teachers whom we observed exhibited a striking lack of awareness of all but the most superficial aspects of Indian and Eskimo culture, and particularly of the language patterns as they relate to understanding and speaking English" (p. 215).

In this chapter, inservice training and continuing education are used synonymously. These terms refer to a carefully designed, organized, and executed enterprise that is ongoing. It involves a specific audience who has an identified need(s) for learning some knowledge or skill which can be acquired through different means in varied settings. And, most importantly, all inservice activities are evaluated and contain follow-up opportunities.

Several general guidelines for developing inservice programs are described in this chapter, along with descriptions of the major factors which will affect the planning effort. Then, several special conditions are discussed for the planner considering inservice training programs for those working with American Indian and Alaska Native children, parents, service planners, leaders, and service providers.

SEVERAL GENERAL GUIDELINES FOR INSERVICE EFFORTS

To help provide direction to the overall inservice planning and implementation process for a tribal group, native corporation, public or BIA school, or other agency serving preschool handicapped children and their families, the following general guidelines are presented -- in no order of importance:

- Know your audience; that is, identify the beneficiaries of the training. In doing this, ascertain crucial information such as level of schooling, cultures or backgrounds represented, and kind of work or personal experiences the audience will bring to the inservice experience.
- Clarify your view or philosophy toward adult learning. Does your audience want to learn what it is you are prepared to teach through the inservice experiences? How do you assess or deal with different learning styles and rates of learning? How do you view the learners and their abilities to acquire new knowledge, skills or attitudes? How much control do you give adult learners in the learning process? How do you motivate them?
- Decide upon what kind of blend or emphasis your inservice will take. That is, do you prefer to improve individuals, change or improve your organization, or both?
- Clarify the nature of your handicapped children and the family population served by the program. This information will help to pinpoint the content or topics of your program.
- Identify and determine who is responsible for coordinating the entire inservice effort.

- Gain various levels of commitment and support for your efforts (e.g., from administrators, staff, parents). Your effort should dovetail with the local policies and procedures of the tribe, school system, or native corporation, as well as with the State or BIA Comprehensive System for Personnel Development required under P.L. 94-142.
- Understand and be sensitive to the nature of the community in which the preschool program is located. Attend to special features such as socioeconomics, culture, topography, language, religion and customs that must be considered for inservice planning and implementation purposes.
- Develop a framework for planning by delineating your audience, assessing their needs, setting objectives and priorities, and establishing alternative delivery means, evaluation and follow-up schemes. The framework should nurture continuity, and provide a way of offering advice and counselling which is responsive and thoughtful to the audience(s) for the training. [For an example of a framework, refer to an article by Trohanis and Jackson (1980).]
- Be cognizant of the degrees of active or passive involvement that you desire from individual participants as they engage in the inservice training.
- Determine how you will help support the transfer of new ideas, attitudes, or skills from the inservice setting to that of the classroom, center, or home.
- Examine your desire and capability for tapping diverse training resources such as universities, colleges, community colleges, community resources, private consultants, and the like for implementing the inservice enterprise.

By clarifying his thinking and general position toward these guidelines, the planner can better focus on more specific inservice problems. This part of the chapter examines the interrelated issues of inservice support and coordination, audience delineation, content options, needs analysis and objective setting, delivery methods, evaluation, and follow-up. See Figure 1 for a schema of these particulars.

Support and Coordination

It is vital to have broad support and appropriate local sanction for undertaking the inservice effort, and to have someone or some agency be responsible for overall coordination. With broad acceptance and proper leadership, the enterprise can develop in numerous directions. For example, an advisory committee or task force might be formed and composed of early childhood staff, representatives of the intended audience, service providers, and community persons to help in the entire planning and implementation process -- i.e., to identify needs, set goals, and suggest activities.

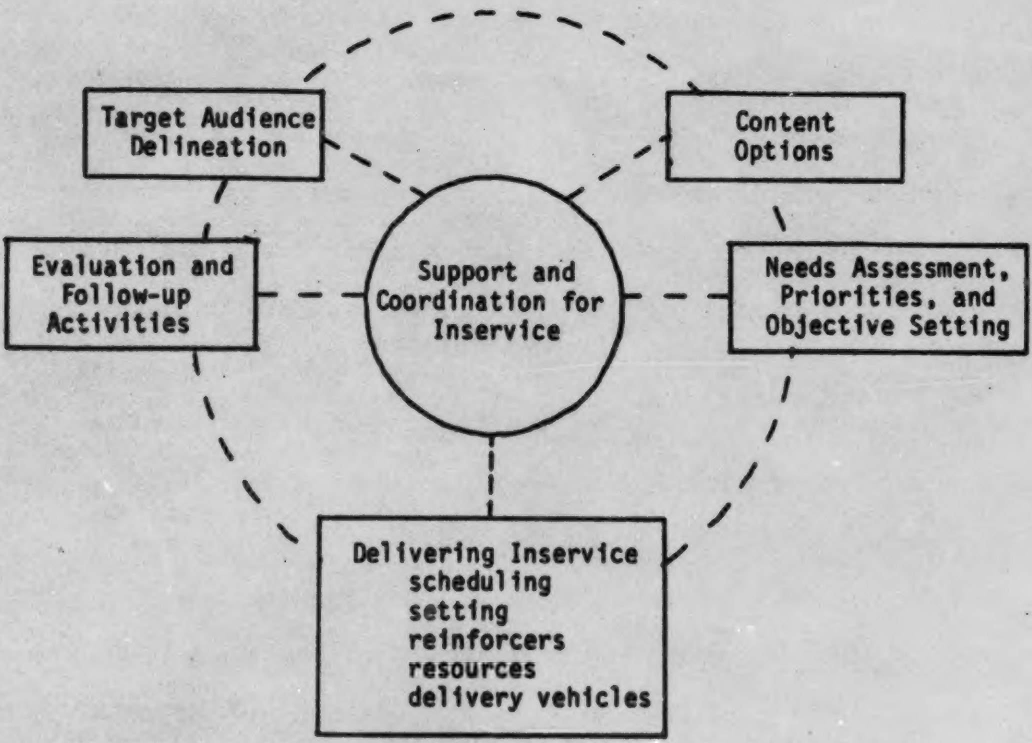
Additionally, liaison personnel need to be trained to foster cooperation with community groups, varied resource organizations, the managers of the State and/or BIA Comprehensive System of Personnel Development, local service providers, and tribal, school or corporation leadership. Also, appropriate policies and procedures for expediting the entire inservice process may need to be developed if they do not exist. Perhaps the advisory committee or task force could help in this area. Finally, a budget must be developed, and key inservice staff or personnel hired or appointed to carry out specific tasks on an ongoing basis.

Target Audience

After support and responsible leadership have been established, it is

FIGURE 1

Key Components for Planning
and Implementing Inservice Training


Target Audience Delineation
Content Options
Evaluation and Follow-up Activities
Support and Coordination for Inservice
Needs Assessment, Priorities, and Objective Setting
Delivering Inservice
scheduling
setting
reinforcers
resources
delivery vehicles

necessary to delineate the audience(s) for the continuing education effort. The following is a list of possible target audiences who might participate in some type of learning experiences. Notice that audiences may be defined broadly or narrowly:

- Teachers (e.g., general, special, Indian-Alaska Native educators)
- Family members
- Social workers
- Tribal, school, or native corporation leadership persons and education committee members
- Bureau of Indian Affairs (BIA) or other federal personnel
- Specialists such as occupational-physical therapists, speech-hearing clinicians, school psychologists, optometrists
- Head Start staff
- Paraprofessionals and aides
- Preservice teachers from nearby colleges or universities
- Mission or private school personnel
- Health and dental professionals

Content Options

Depending upon the audience selected for inservice, planners pinpoint or outline the content of the training that will be provided. This type of preliminary delineation can be accomplished even before a needs assessment is undertaken, because, most often, the nature of a given target audience suggests the selection of certain content. For example, if school principals or superintendents are the targets, it is most likely that they will be interested in such early childhood special education (ECSE) content as service program alternatives; a rationale for serving young exceptional children; interagency cooperation; compatibility of this type of service program with current local practices, staffing, and costs.

Another example: if teachers were to be the targets of inservice efforts, planners could assume that the following ECSE content topics might be appropriate -- classroom organization arrangements; mainstreaming techniques; information about handicapping conditions, behavior management, and non-discriminatory testing; use of culturally-relevant curricular materials, screening techniques or home visitation strategies. Other content for teachers may range from health practices, parent involvement, nutrition, mental health, awareness of tribal culture, and the breaking of stereotypes, to bilingualism. (Refer to the matrix in Figure 2 which provides a method for matching audiences with content.)

Of course, additional information is necessary to determine content. In particular, planners need to know something about the types of handicapped preschoolers (ages birth through five years) and their families with whom the audience works. Are the children and families monolingual or bilingual? What is their life style in terms of child-rearing and religion? How do the families perceive and accept handicapping conditions and special education services?

Needs Assessment, Priorities and Objectives

By having a notion of the audience and content options, the planner can begin to determine the more specific inservice training needs and interests of the persons involved in providing services to the children. A number of strategies can be used to help find out what people need or want to learn. These include:

- a written report of self-perceived needs by the audience;
- a paper and pencil survey or profile indicating the degree of need by the audience for particular content areas;
- a formal written testing procedure to find out what the target audience already knows in order to design inservice around what they do not know;

FIGURE 2

A Matrix to Help Match Target Audience with Content for Inservice Training*

	Possible Content for Inservice					
Possible Audiences for Inservice	Service Program Alternatives	Mainstreaming Techniques	Nondiscriminatory Testing Procedures	Culturally-Relevant Language Materials	IEP Writing and Monitoring	Behavior Management Practices
Principals						
Teachers						
Speech Therapists						
School Psychologists						
Tribal Leaders						
Families						
Head Start Staff						

Note: This matching process depends on other important factors such as the age of children being served, types and severity of handicaps, type of service program, and the final results of the needs assessment.

- recommendations for training from an advisory committee or task force;
- an informal, face-to-face interview with the inservice audience to ascertain their needs; and
- making recommendations and inservice plans based upon a period of observation of the target audience by the inservice planner.

Once information is gathered, the planner must analyze it and delineate the specific content and topical areas of training. Also priorities must be assigned to those areas. Here, an advisory committee or task force might be helpful.

With priorities in mind, the planner can begin establishing certain goals and objectives for the training effort. It might be helpful to create two levels of objectives: one set for fulfillment by the whole audience, and one set for individuals. In the long run, all objectives should relate to the knowledge, attitude, skill or behavioral outcomes, changes or improvements that are sought by the audience. An individual inservice plan might be negotiated and prepared for each participant that would cover a school-year's worth of goals and opportunities.

After priorities and objectives have been established, the planner is cautioned to be flexible. That is, a need for or interest in inservice programs may vary over time with your audience. Hence, be prepared to try and accommodate a unique or unusual ECSE need that may arise with minimum disruption to the rest of the program.

Delivering Inservice

Once objectives have been determined, a host of factors related to the actual delivery of training must be considered. They include scheduling, settings, reinforcers, resources, and delivery vehicles. Each factor is discussed briefly.

Scheduling. This factor is crucial on two counts. First, inservice must be provided so that it supports the audience who is charged with completing certain tasks. For example, if screening is to be done in August, the screeners need training before August. Thoughtful scheduling requires matching the priorities established for training with the work calendar of the training recipients.

Second, it is important to present a schedule of the many specific inservice activities so that plans can be made in advance by the audience. It may be important to avoid, for example, certain Indian religious celebrations or Eskimo holidays. Even with a schedule, you may have to be flexible. If the tribe decides to hold a ceremony when training was scheduled, "the Pueblo is closed;" that means no inservice on that day -- it will have to be rescheduled. Finally, scheduling should take into account that there are certain times of the year that are bad for "one-on-one" inservice -- the winter, in many parts of Alaska.

Setting. Inservice training may be given in many settings, depending on such things as needs, goals, audience, location of participants, and technology available. It can be held in school or college classrooms; in a van or on the reservation or in the village where young handicapped preschoolers are being served; or, it can be brought to the audience through technological means such as TVs, radios, computer terminals, newspapers, or telephones. Finally, inservice can be undertaken and pursued in the comforts of one's own home. So be open minded about the different environments for learning.

Reinforcers. Planners must decide if certain external reinforcers need to be built in to encourage participation in the training, or if the participants' needs to learn will be sufficient. For example, should the inservice program offer participants continuing education units (CEUs), released time, extra compensation, and stipends for travel or per diem expenses? Should course credit be bestowed or renewable certification allowed? Should inservice training provide a basis for salary increases? Finally, should inservice be tied to a career ladder?

Resources. As the education program begins to take shape, the planner must be aware of those diverse resources which can or need to be tapped. What skills are available on the early childhood program staff? In the community? At a Head Start Area or BIA Agency office? In the State Department of Education? Is there money for consultants and travel? What print and audiovisual materials are available? Are there facilities for producing some training materials? Are there funds to rent or purchase some materials? Can technical assistance agencies such as universities, community colleges, Regional Resource Centers, state offices of the National Diffusion Network, Handicapped Children's Early Education Projects, and the State Department of Education -- provide resources?

Delivery Vehicles. There are many different vehicles available for delivering inservice education. In the final analysis, the ones used should be selected after goals, audience, setting, content to be conveyed and its sequence, resources, and reinforcers have been determined. Here is a sample of delivery vehicles that incorporate individual and small or large group strategies:

- Independent study -- a very flexible vehicle that stresses self-instruction with readings, correspondence courses, audiovisual materials, and/or mass-media technologies such as TV, radio, or newspapers; can be used extensively in rural and isolated geographic areas.
- Lectures -- an efficient way for conveying information to a large

number of people gathered at the same time and place.

- Group discussion -- this form allows for a small number of people to exchange information and points of view. A good technique to promote sharing of ideas, problem solving, and learning specific skills.
- Audiovisual and print media -- these forms include such diverse items as manuals, handbooks, filmstrips, slidetapes, films, records, videocassettes, audiotapes, and overhead transparencies that can be used in individual, small or large group circumstances.
- Seminars -- a variation on group discussion that permits a small number of people to explore some specifics in greater depth and detail.
- Field visits -- this strategy gives people an opportunity to see first-hand other preschool practices, approaches, or techniques that might be replicated or instituted back home.
- Demonstrations -- these can be used to illustrate the use of procedures or materials. An itinerant trainer can show a teacher "in the bush" how to teach flossing to young handicapped children.
- Simulations -- these may occur in small groups and include such strategies as role playing or problem solving.
- Conferences, institutes, workshops -- these are of two types. First, there are those that are designed specifically by the inservice program to facilitate information exchange, group interaction or information transmission. Second, there are those meetings that are arranged already (e.g., professional conferences, regional workshops) and participants may choose to attend or not.
- Consultants -- these people present an opportunity to work in a

> flexible manner, one-on-one with a client, to solve problems. They may give a demonstration, provide new information, help make decisions, serve as a role model, or act as a catalyst for change. The consultant can go to the client or the client can travel to the consultant.

Obviously, the delivery vehicle(s) must be matched carefully with the audience, its location and size, objectives, setting, reinforcers, nature of content, time available, and the availability of resources. Naturally, specific planning for each delivery strategy must be undertaken -- including evaluation and follow-up.

Evaluation and Follow-up

It is vital to monitor the efficiency and effectiveness of the inservice effort -- through its objectives and activities. Have knowledge and/or skills been acquired? Have changes occurred in morale or attitudes? Were the teaching activities or delivery vehicles satisfactory? How was the sequence of presentation? Were the materials and speakers adequate? Was the environment conducive to learning?

Documenting both changes in the audiences and inservice activities undertaken are important. Therefore, some sort of data-based gathering and reporting process is needed that uses instrumentation such as tests, checklists, questionnaires, observation accounts, or written reports. (See Figure 3 for an example of a workshop questionnaire.) By collecting information systematically, inservice planners can monitor the program's progress and make appropriate changes while being accountable to those administrators sanctioning the entire effort.

Based on feedback from inservice participants, planners must develop approaches that facilitate follow-up activities. In this way, inservice

Workshop Questionnaire Example

Topic/Content Focus ____________________

Dates _______________

Place/Location ________________________

Workshop Coordinator ___________________

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Instructions: Please rate, check, or list your responses regarding the workshop on the following items.

	Unsatis-factory		Average		Excellent
I. Quality of Workshop (please circle your response)					
1. Work with consultant (if applicable)	1	2	3	4	5
2. Group presentations/discussion	1	2	3	4	5
3. Organization of workshop	1	2	3	4	5
4. Materials/handouts/media	1	2	3	4	5
5. Location/facilities	1	2	3	4	5
6. Sharing of ideas and concerns	1	2	3	4	5
II. Satisfaction with workshop (please circle your response)					
1. Extent to which workshop met your interests/needs	1	2	3	4	5
2. Usefulness of workshop to you	1	2	3	4	5
3. Overall satisfaction with workshop	1	2	3	4	5

III. Description of Workshop Accomplishments

1. What were the main accomplishments for you from this workshop?

____

____

IV. Comments about workshop

1. What were some strong points of workshop?

____

____

2. What were some weak points? ______________________________

3. Other comments: ____

Person Completing Form: ______________
(name)

can indeed be ongoing and continuous, ever evolving to meet the changing needs of individuals and the groups to which they belong.

SPECIAL INSERVICE FEATURES

Up to this point, general inservice education topics have been addressed. Now, the special features that must be addressed when planning and implementing inservice training in communities serving the needs of young handicapped children of American Indian or Alaska Native background will be considered -- not necessarily in order of importance.

Sensitivity to Heritage

The richness of American Indian and Alaska Native history, the strengths and values of their culture and religion must be considered for all inservice endeavors. All planners and trainers developing inservice training activities, regardless of their own ethnic background, must demonstrate an awareness and appreciation for such things as the dignity and self-esteem of individuals, the value of the extended family, the concept of time, and linguistic differences. The credibility and effectiveness of inservice can be enhanced by being aware and responsive in these areas.

Language

Inservice plans and activities must take into account and be sensitive to the linguistic differences that may prevail among children, families, and service providers in different locales. For example, Ypik, Inupiat, Lakota, Navajo, or a reservation dialect may be the preferred or dominant language. Consequently, inservice trainers may need instruction in its proper use or may need to make use of interpreters during certain inservice experiences such as workshops, consultations, or demonstrations.

Learning Materials

Instructional materials, literature, handouts, and audiovisual products that are used for inservice must be authentic and appropriate for the tribe. Cultural stereotyping must be avoided. If appropriate materials are not available, the inservice trainer may need to design and produce pertinent ones.

Modern vs. Traditional Community

Planners and trainers must be aware and sensitive to the changes occuring in many Indian and Alaskan communities. That is, more modern, urban ways (e.g., multilingualism) seem to be intruding on reservations, villages or isolated areas where the traditional way of life has been strongest. "Traditionalism" refers to features such as using the native language, generally maintaining close family ties and religious rituals. Hence, an understanding and sensitivity to the environment in which inservice will take place is crucial for the trainer or consultant.

Distances, Topography, and Climate

Implementing an inservice program in Alaska or on many reservations can be complicated by differences in time, space, climate and terrain. For example, some preschool service providers are 400 air miles from the nearest city, and perhaps college or resource center. Bad weather such as snow in the Rockies, volcanic eruptions in Washington or floods in the Midwest can be devastating and isolating, and they can cancel valuable, needed learning time. Finally, roads can be impassable in many places during the spring thaw, making group transportation and personal, follow-up consultation impossible. So, be cognizant of these special features and plan to be flexible and creative in dealing with them.

Jurisdictional Authority and Responsibility

It is imperative that the inservice program work within the appropriate jurisdictions and administrative channels of the tribe, native corporation, state, reservation, public or private school. Also, it is important to know who is responsible for and involved in planning inservice training in any given locale -- i.e., BIA, Head Start, public schools, technical assistance agencies, and colleges.

Keeping Staff and Continuity

Turnover of early childhood program staff is a major problem in Alaska, on Indian reservations, and in rural areas. It might be reduced by responsive ongoing inservice efforts. Even with low pay or uncertain funding, perhaps some sort of career development through inservice may counteract some of the moving away to other jobs.

We must ensure continuity of preschool program practices, sensitivities, and procedures. As staff depart our programs, all efforts must not come to a halt or have to be reinvented. Perhaps training manuals should be developed to help new staff make smooth transitions into programs and into their particular responsibilities.

CONCLUSION

Inservice training must be an integral part of the programs serving young handicapped American Indian and Alaska Native children and their families. To enhance its effectiveness, inservice efforts must be ongoing and responsive to adult learner needs. Additionally, inservice must be designed and implemented carefully and sensitively. Above all, the enterprise must be accountable and allow for follow-up.

Inservice planners must orchestrate a systematic approach to training for adults that is attuned to things such as linguistic and cultural differences, the need for appropriate curricula and instructional materials, jurisdictional authority, climate and transportation barriers. Furthermore, planners must treat the learners as adults who are self-directing and have a wealth of experience. As a consequence, creativity, flexibility, and positive determination must permeate the planning and implementation process. In this way, early childhood programs can attract and keep competent staff, improve practices that will enhance positive child and family growth and development, help prepare people for new roles or jobs, and respond to the unique needs of the locale and community.

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CHAPTER 8

Managing the Planning and Implementation of Preschool Programs by *Pascal Louis Trohanis*

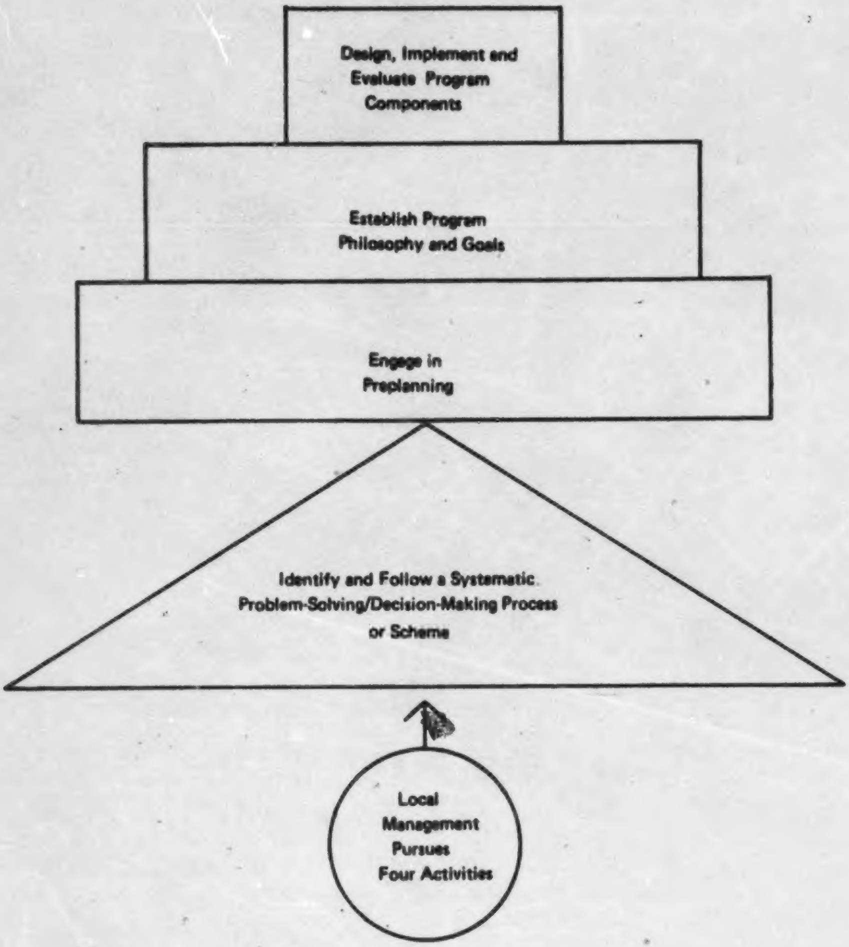
> The process of running an early childhood program is usually all-of-a-tangle, with a number of variables being dealt with at any one time, all dependent upon one another and all affected when one is changed (Hewes, 1979, p. 1).

This final chapter examines the multiple facets and complexities involved in the overall management of the planning and implementation of programs serving young American Indian and Alaska Native handicapped children. To assure success in this dynamic undertaking, the author suggests that four related activities should be pursued and acted on carefully by the local program manager, advisory council, and/or governing board. (See Figure 1 for a description of these four activities.)

The first activity involves adopting a systematic problem-solving or decision-making model. The adoption and use of such a framework will help in continuously guiding the entire management process. Next, preplanning should be undertaken. This activity consists of developing an awareness of and a position toward major influences on the preschool program. The influences include such things as tribal/community history and needs, culture, state and Bureau of Indian Affairs (BIA) policies, and national laws. Third, with preplanning completed, a statement of philosophy to guide the program and its beneficiaries should be developed along with general goals, activities for attaining them, policies and

FIGURE 1

Four Activities Which Management Should Pursue
in the Overall Planning and Implementation
of a Preschool Program


Design, Implement and Evaluate Program Components
Establish Program Philosophy and Goals
Engage in Preplanning
Identify and Follow a Systematic Problem-Solving/Decision-Making Process or Scheme
Local Management Pursues Four Activities

standards, evaluation procedures, etc. Lastly, a plan of action for ten program components (many of which have been discussed earlier in this book) should be finalized, implemented, monitored, and modified as necessary.

Management coordinates these four activities; it builds and operates the program in a thoughtful, systematic, public, and efficient manner. Furthermore, management requires and thrives on information, effort, and human interaction. It builds a program for young exceptional children and their families that provides appropriate and qualitative educational opportunities and related services. The successful key to supervising this entire process is skilled leadership. That is, an early childhood program needs a cluster of persons who are willing to work as a team and take on the inherent challenges and responsibilities of planning and implementing the program. Above all, the leadership must be honest, humane, sensitive, competent, trustworthy, and skilled in working with the talents of others.

PROBLEM-SOLVING AND DECISION-MAKING PROCESSES

Effective leadership requires the use of a systematic approach in planning, problem solving, and decision making. By having a conceptual process as a foundation and guide, the manager or management team can better determine the nature of certain influences on specific program problems or needs, establish a philosophic statement and program goals, and delineate program plan components. Furthermore, this systematic approach can provide an opportunity for measuring whether or not certain accomplishments occurred.

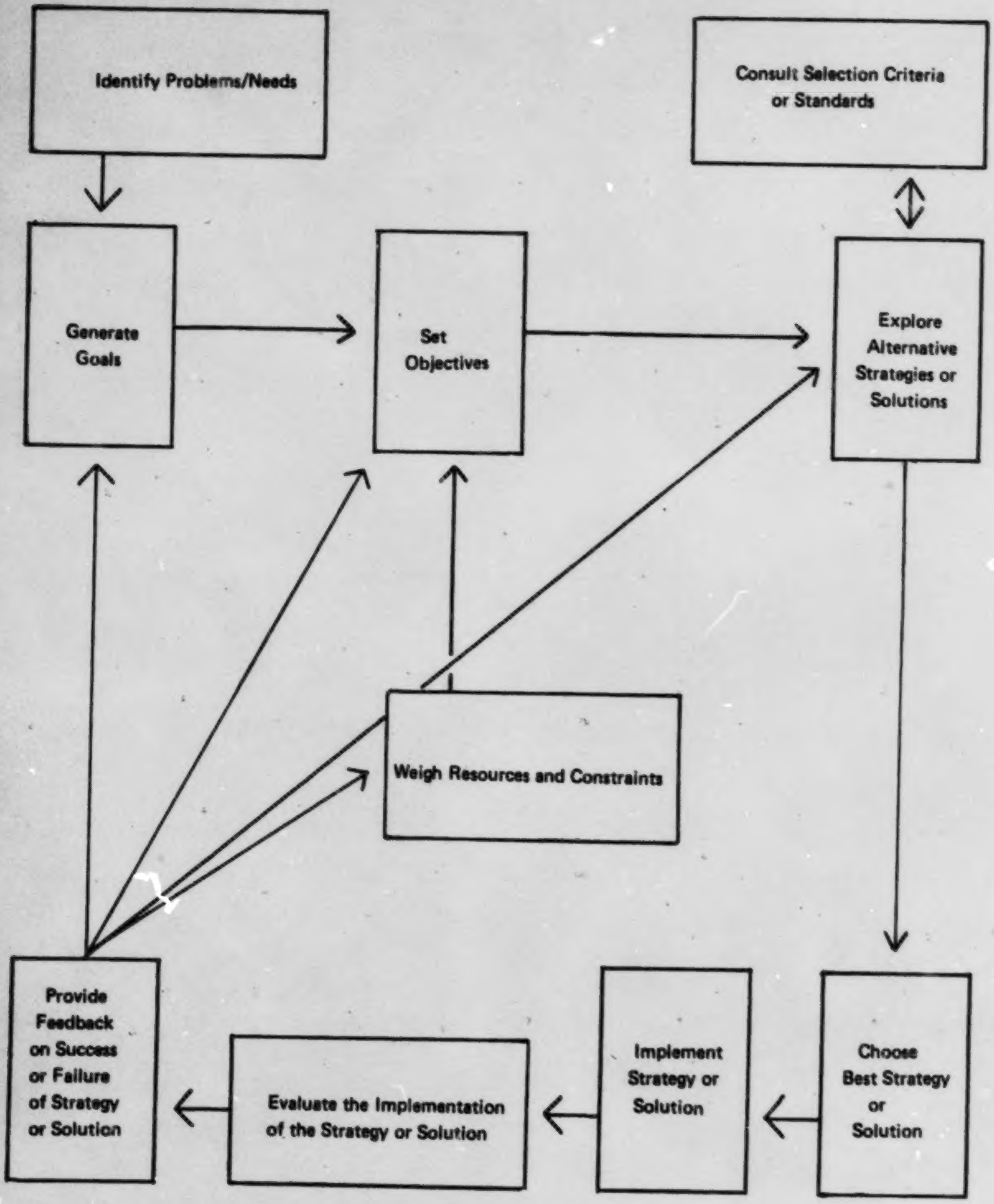
There are many approaches to (or models of) problem solving. Only one is portrayed in this chapter. It was synthesized from a scheme designed by the Technical Assistance Development System (TADS) of Chapel Hill, North Carolina, in 1973, to help personnel of preschool programs design services for young handicapped children and families. Figure 2 is an adaptation of the scheme that appeared in a 1973 monograph by Gallagher, Surles, and Hayes. According to them, the elements of this approach are sequential and interrelated. The model may be described briefly as follows: Needs or problems alert managers to areas requiring a change or action. Goal statements, revealing broad intentions, are developed on the basis of these needs. Goals give rise to objectives which describe more specific intentions, are measurable, and have timelines. Objectives can be met or realized only within the boundaries of available resources and constraints. Next, managers describe several strategies for achieving each objective. Each strategy is assessed by consulting selection criteria such as quality standards or timelines. After having weighed the pros and cons of each strategy in light of the criteria, the management team makes a decision and chooses the best strategy. Then, appropriate steps are taken to implement the strategy. Later on, it is evaluated in terms of its success or failure. Finally, the evaluation data is used in adjusting or setting new goals, improving resources, or sharpening objectives.

Again, whether one uses the conceptual scheme represented in Figure 2 or another one, it is important to have available a systematic approach to guide the preschool program's decision-making, planning and implementation efforts. Such a scheme may be used by a program manager or administrator, tribal council, tribal or native corporation education committee, advisory council, school board, or other group or person charged with managing the planning and implementation process. Of course, the ground rules surrounding the use of the model must be clarified for the next activities of preplanning, setting philosophy and goals and planning actions.

PREPLANNING ACTIVITY

By having a model and a method for involving people in its operation,

A Problem - Solving, Decision - Making Model


Identify Problems/Needs
Consult Selection Criteria or Standards
Generate Goals
Set Objectives
Explore Alternative Strategies or Solutions
Weigh Resources and Constraints
Provide Feedback on Success or Failure of Strategy or Solution
Evaluate the Implementation of the Strategy or Solution
Implement Strategy or Solution
Choose Best Strategy or Solution

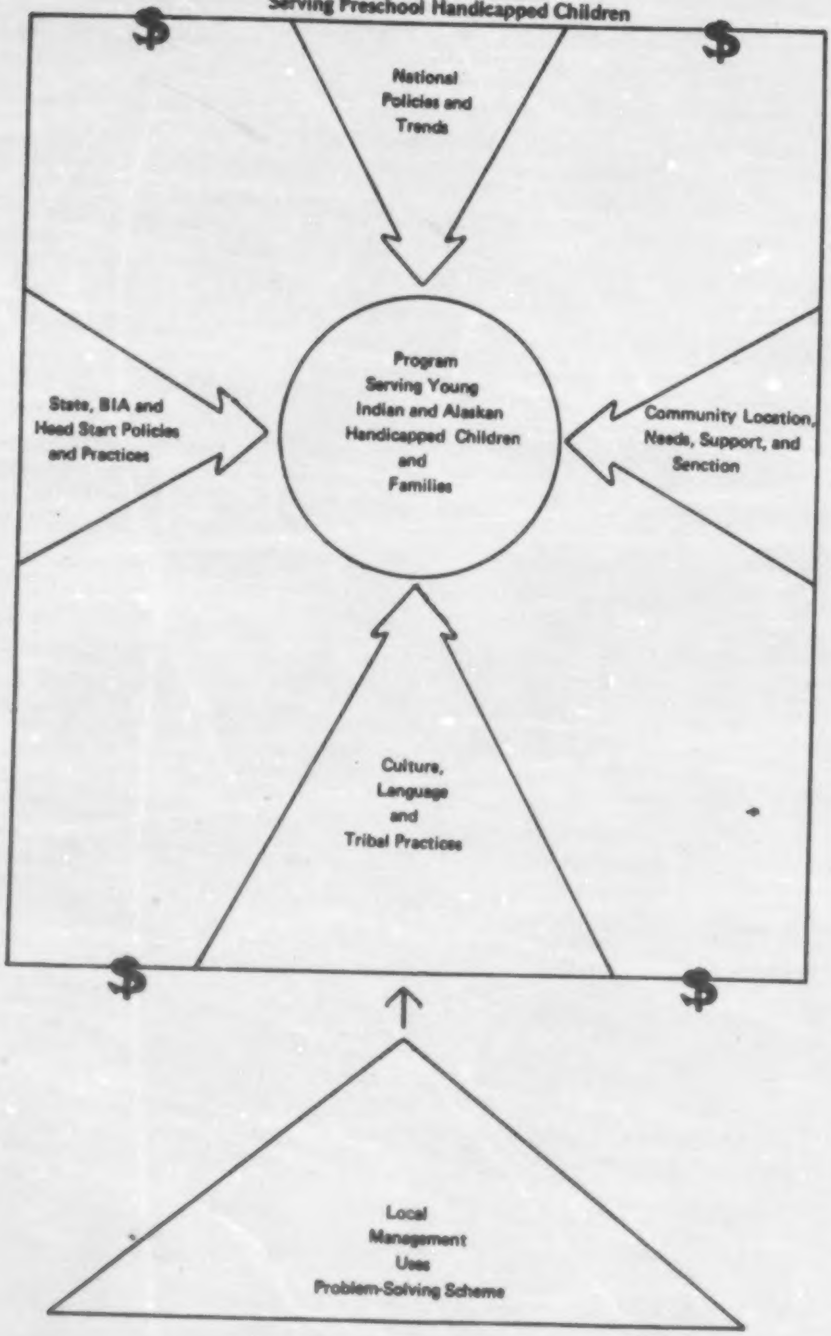
the manager can put it to use in preplanning. This task involves identifying and analyzing four major program influences -- community, cultural, state, and national -- which affect the local education of young Indian and Alaskan children. Of course, this analysis must be tempered by the realities of available resources. In each of the four areas in Figure 3, the manager must put the decision-making model to use. Needs must be identified, objectives set, and alternative solutions explored and selected. By the end of preplanning, agreement about the most pertinent influences which will underpin the design and implementation of the early childhood education program should be reached. A short description of each major factor follows. Of course, there is overlap among these areas of influence.

Community Influences

The desires, problems, hopes, and needs of the community must be assessed. Regardless of the local setting (e.g., reservation(s), Alaskan Native Village(s), rural, urban), one must find answers to the most pressing and pertinent questions. Here is a list of some questions that need to be considered:

- What kinds of preschool services, if any, are offered currently in the community? Are people satisfied with them?
- What are local priorities, in general, for serving young children with special needs?
- Are there young handicapped children and families presently not receiving services in the community?
- What are the ages of these children and the types and severity of their handicapping conditions?
- Are there community resources available for developing and implementing a preschool program?

FIGURE 3
Preplanning: Identify and Analyzing
Major Influences on a Program
Serving Preschool Handicapped Children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National Policies and Trends
State, BIA and Head Start Policies and Practices
Program Serving Young Indian and Alaskan Handicapped Children and Families
Community Location, Needs, Support, and Sanction
Culture, Language and Tribal Practices
$
$
Local Management Uses Problem-Solving Scheme

- Does the community location or geography pose special service delivery problems that must be considered?
- Is there adequate community support to initiate preschool services from such groups as parents, elders, corporation leaders, and tribal officials?
- Can a partnership among various agencies be created and continued for planning and implementing services?
- What should the community's expectations be in the long and short run with respect to the preschool program?
- Has there been any prior conflict or tension in the community over providing services to young handicapped children?
- What is the nature of local power and decision making that may influence the entire program planning and implementation effort?
- Is the local economic situation such that it can continue supporting a preschool program over a period of time?
- Are there community preferences as to the type of setting(s) for serving the children and families?

Cultural Influences

To say the least, the nations of Indians or groups of Alaska Natives differ from one another in many ways. As a consequence, managers must analyze and make decisions about the most important cultural influences to be considered in the design of their preschool program. The following is an outline of some questions that must be addressed:

- What role should the extended family have in planning and participating in the program?
- What perspective should prevail on the use of native language in the preschool program?

- What and how much history and culture should be stressed in the curriculum and instruction for children and families?
- Are there special economic considerations or sensitivities that must be addressed?
- How should the distinction between urban and rural life styles be handled (tradition versus modernity)?
- Are there unique political, decision-making, or sanctioning practices that must be followed as the program is planned and implemented?
- What are relationships between local leadership and federal or state program personnel?
- What role should religious customs play in the final design of the preschool program?

State Influences

There are diverse factors in each state which can influence the development of a local program for young children with special needs. Here is a sample of key questions which must be explored and answered:

- What priorities and capabilities for serving young special children prevail in BIA or state-supported (public) schools?
- What is the state and/or BIA mandate for serving young children with special education?
- Is there an age requirement for kindergarten attendance?
- Are Head Start programs satisfying their mandate by allowing ten percent of their enrollment opportunities to be handicapped?
- What statewide efforts exist through day care, demonstration or outreach projects from the Handicapped Children's Early Education Program of the U.S. Department of Education, or other agencies?
- Is there a preschool component to the state's and/or BIA Public Law 94-142 plan, and is there a preschool incentive grant program?

- What pertinent federally funded training activities exist that may be tapped?
- Are there "regular" Indian education or bilingual programs that serve young handicapped children in the state?
- What plans and priorities has the state Developmental Disabilities Council set for young handicapped children?
- Is there any special statewide planning going on for young children with special needs?
- Are there state standards, rules or guidelines for preschool handicapped children?
- Are there preschool teacher certification requirements?
- Do plans for health services exist for these youngsters?
- What sources of funds are available for programming and providing other related services?

National Influences

Finally, varied national influences must be scrutinized. The most important ones must be discussed and dealt with since they will affect the ultimate management of a local preschool program. Some of the national questions that must be addressed include the following:

- What are the implications of Public Law 94-142 and such things as nondiscriminatory testing, IEPs, due process, and the least restrictive environment?
- What pertinent judicial rulings on bilingual, special education, and Indian education have precedence?
- What trends in early childhood programming should be considered seriously for implementation?
- What funding sources are available to help start or operate programs?
- What BIA program trends prevail in such areas as public school

assistance programs:

- Does the philosophy of cultural pluralism prevail nationwide?
- What is the availability of new preschool curricula and instructional materials?
- Are the high incidence figures of otitis media among these populations being addressed properly?
- What will be the impact of the new regulations for the Indian Education Act?
- How will the economies of reservations and native corporations affect preschool efforts?
- Are improvements being made rapidly enough in such areas as roads, health services, housing and communications and thereby enabling a good environment for preschool services to survive and thrive?
- What is Head Start doing nationally?
- What will be the impact of the new U.S. Department of Education?
- How will crises such as the taxpayer revolt, high fuel costs and inflation influence the preschool program?

Managers, advisory councils, or boards of education can undertake and fulfill preplanning activities more easily and expeditiously by using a systematic problem-solving model. Preplanning calls for developing an awareness of major influences, analyzing them, and determining the ones most relevant in efforts for preschool handicapped children. Preplanning is best done on a group basis to capture a wide variety of opinions, needs, and views. Membership in the group may include parents, administrators, teachers, tribal leaders, and so on. Furthermore, the planning group may wish to have representatives from different types of schools found in the community. Finally, the group may wish to develop or use a systematic planning instrument. For example, the "Handicapped Services Needs Assessment" device developed by Guidera (1979) of the Office of Indian Child Services in Yankton, South Dakota, helps to identify salient features for designing a preschool handicapped program.

To assure that the preplanning activity is successful, it is recommended that decision-making procedures be clear from the outset with respect to how information will be collected, analyzed, prioritized, and other decisions made. Lastly, a written record about these proceedings is suggested. This record can serve as a useful tool for the next planning and implementation activity, and provide a historical perspective for general future reference.

OVERALL PHILOSOPHY AND GOALS

A natural extension of preplanning (wherein major influences, as well as problems, needs, and resources have been identified, analyzed and agreed upon) is to construct the overall philosophy and goals that your program will have for serving young children with special needs. For this activity, you must determine the assumptions upon which your program will be based. This rigorous effort must take into account the bringing together of practices and ideas from special education, early childhood, and Indian or Alaska Native education.

The following is a sample of questions that must be posed and answered by the management team in order to determine ultimately the general direction that the preschool program will take:

Early Childhood

- What are your beliefs about children and learning?
- How do you view human development and to what theories do you subscribe (e.g., behavioral, interactionist, maturational)?
- How best are morals and ethics developed in children?
- What importance do you give to various areas of knowledge (e.g.,

art, music, science) and the dimensions of cognitive, affective, linguistic, motor, and moral development?

Special Education

- How will special children be classified or labeled in your program?
- What progress should parents expect for their child in the program?
- What are the community's feelings about integrating preschool handicapped and nonhandicapped children?
- What record-keeping system is practical to use?
- What about the confidentiality of information?
- What support services should be offered to families?
- What types of family involvement will be offered in the preschool program?
- Do you believe that the community should reach more special children and at an earlier age?

Indian or Alaska Native Education

- How should culture and religion be handled in the curriculum?
- Are home- and center-based settings for learning acceptable in the community?
- Should there be a mix of individual and group learning experiences for children and parents?
- What about jurisdictional priorities involving BIA, public schools, private schools?
- How best should the self-image of the children be enhanced?
- Should the program be monolingual or bilingual?
- Can (or will) different service agencies charged with serving Indian children cooperate?

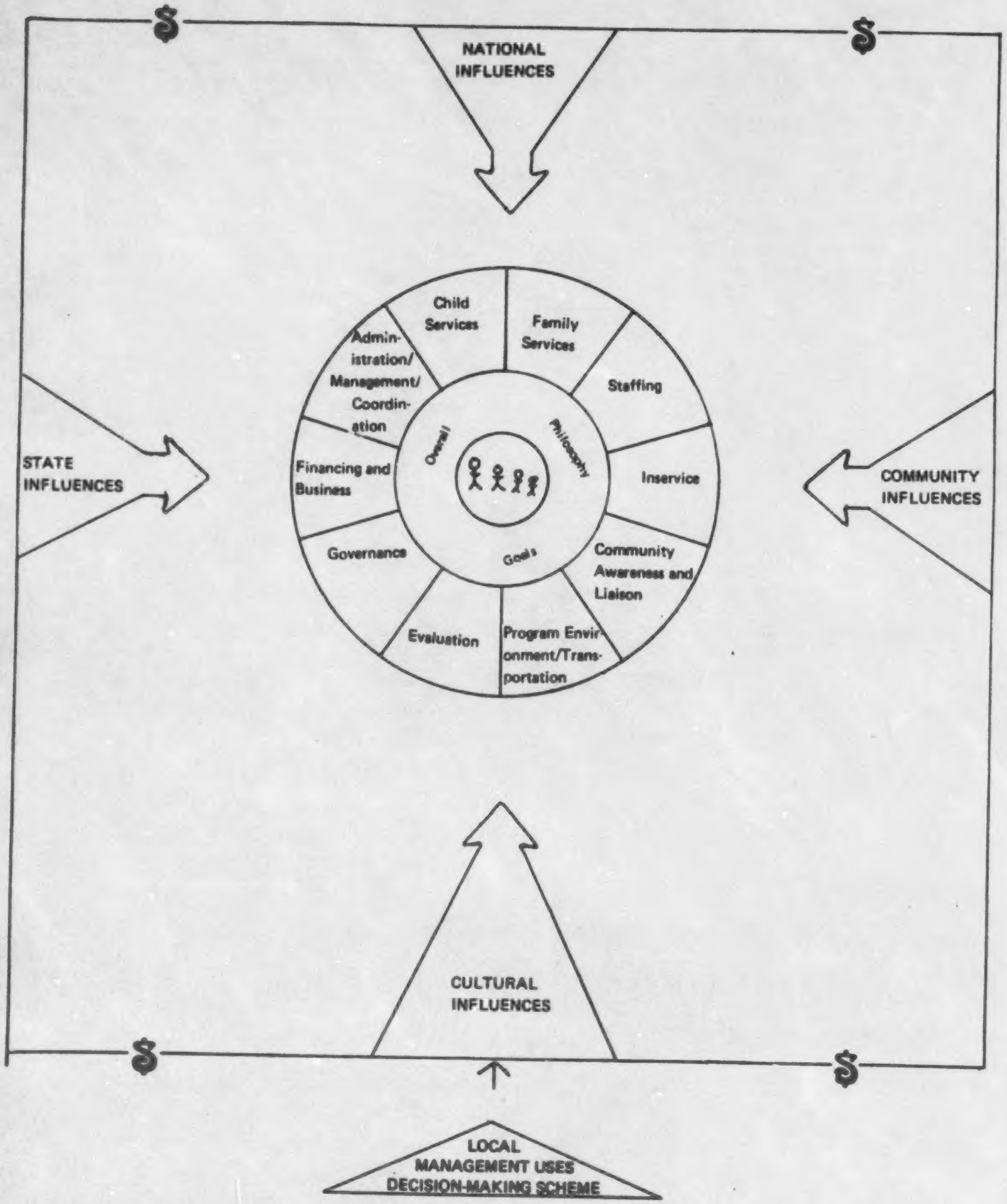
Raising and answering questions is a tedious and often complicated task. But it is necessary in order to draft first a written statement of overall program philosophy, and second to develop goal statements. Both of these products will provide a sense of direction and mission in the community preschool. Both statements, tempered by constraints, resources, and reality, should be stated to describe the general intentions of the program -- in other words, what will be done, by when, and why. Once accomplished, these ideas will serve as primary building blocks for the remaining planning and implementation activities.

ACTION PLANNING BY PROGRAM COMPONENT

A systematic decision-making model has been selected and is being followed. The preplanning is done. Also, the management team has a written statement of overall philosophy with some general goal statements, and perhaps suggestions of tentative objectives, strategies, criteria, and evaluation procedures. Now, the focus must shift to the activity of constructing and operating the specific preschool program around the skeleton of ten basic program components. (See Figure 4 for a schema of the components that require action planning. This Figure also depicts the major influences and philosophy described earlier.)

Each of these ten components is described briefly in order to give managers an opportunity to see the scope of the many sensitive variables that must be addressed. Of course, many of these variables have been described already in other parts of this text. For each component, however, the manager must set objectives, explore alternative strategies while consulting selection criteria, choose and implement the best strategy, evaluate it, and provide feedback. Finally, as this is done, keep in mind that program components may be influenced greatly by laws (e.g., P.L. 94-142 and Section 504), policies, accreditation, licensing and local practices.

FIGURE 4
Program Components That Require Action Planning


NATIONAL INFLUENCES
STATE INFLUENCES
COMMUNITY INFLUENCES
CULTURAL INFLUENCES
LOCAL MANAGEMENT USES DECISION-MAKING SCHEME
$
$
$
$
Child Services
Family Services
Staffing
Inservice
Community Awareness and Liaison
Program Environment/Transportation
Evaluation
Governance
Financing and Business
Administration/Management/Coordination
Overall
Philosophy
Goals

Child Services

According to Hayden (1977), "children with special needs deserve to have early intervention programs; we need to help each child make the most of her or his potential" (p. 3). The component of child services contains a variety of interrelated parts designed to enhance the total development of the child. The particulars of this component that must be planned and implemented include the following:

1. Determine types, severity of handicapping condition, and ages of children to be served.
2. Establish the eligibility requirement for participation in the preschool program.
3. Undertake case finding and the identification of special children.
4. Screen children and arrange referrals for further diagnosis.
5. Implement comprehensive diagnostic and evaluation activities.
6. Prepare individual education programs (IEPs).
7. Select and place children in least restrictive learning settings.
8. Assess children in order to establish short-term instructional objectives and set up daily plans.
9. Engage children in a curriculum which has a careful sequence of lessons and draws on relevant materials. The curriculum will cover broad areas such as self-help skills, motor and manipulative skills, social skills, affective development, language and self-expression skills, cognition, and culture-traditions-history.
10. Offer and use related services such as health, physical therapy, speech and language, and dentistry. A multidisciplinary or team approach is recommended that will enable an efficient and effective orchestration of all services to the child.

11. Document child progress and parental notices and consent.
12. Prepare children for transition to other community programs and be available for follow-up.
13. Use volunteers and family members in operating aspects of the child services component.

The child services can be offered in diverse settings. For example, a center or school setting can be used, a home, other facilities in the community, or some combination of these.

Family Services

Moore (1974) reminds us that "the amount of time spent in the home indicates that the family and home will be the most influential factors in determining a child's behavior patterns, his or her accumulation of knowledge, social adjustment, communications skills, and so on" (p. 57). Because of this important fact, planners and managers must develop and put in place a responsive and flexible array of family involvement services as part of its preschool program.

To ascertain the interests, needs and skills of the family, resource and needs assessments of family members must be conducted, objectives must be set, appropriate activities developed, implemented and then evaluated and modified as necessary. The approach can be used to deal systematically with the following dimensions of a family services effort: providing social and emotional support to parents; nurturing the exchange of pertinent topical information; keeping families informed of the preschool program; soliciting and using family help in administering and operating the program; teaching parents to teach their children at home or in the classroom; meeting various social, health, psychological, and nutritional needs of family members.

Many different avenues are available for bringing parents into the process. For example, they should participate throughout diagnosis and IEP development. Group discussions and individual conferences can bring them together with professionals, paraprofessionals, and decision makers. Inservice training sessions can be convened in the center or classroom. Newsletters, written reports, or regular telephone updates are all ways that can be used to reach families on a regular basis. For all activities, planners must determine the most desirable schedule, time, and format; and they must consider cultural and language differences.

Staffing

The type of staff needed to populate the preschool program will vary depending upon the program, its overall philosophy, and goals. Regardless of this variation, there must be a leader, that is, a director or coordinator. Also, there will be a mix of primary care givers, early childhood special education teachers, paraprofessionals or aides, social workers, physicians, nurses, interpreters, cooks, bus drivers, community volunteers, psychologists, evaluators, communication specialists, speech-hearing specialists, occupational therapists, cultural specialists, and student teachers. Depending upon the program, the staffing pattern will be a blend of full and part-time people.

Planners must anticipate and resolve staffing matters which concern existing tribal, school or corporation personnel policies. These include recruitment, salary ranges, substitutes, staff benefits, performance criteria, job descriptions, tenure rights, child-teacher ratios, certification requirements, and supervision patterns. They must also recruit and keep quality personnel. This is especially difficult in very rural and isolated areas where housing may be a major problem. Finally, programs must decide the extent to which they prefer to hire qualified Indian or Alaska native personnel instead of persons from other backgrounds. In all, the program must be populated by a sensitive, qualified, and caring staff. Therefore, plan and implement this component carefully.

Inservice

Developing an ongoing inservice training component is vital to the preschool program. It must be systematic and responsive to the needs of diverse personnel -- e.g., program staff, paraprofessionals, community members, parents, principals, tribal or native corporation leaders, and teacher trainers. If it is integral to the program, training can accomplish a variety of things, such as improving staff skills, orienting people to certain practices, developing parent skills, and preparing staff for the new and perhaps multiple roles that they must play.

The content of the training will vary depending upon the audience and the results of a needs assessment. Topics may include language development, nondiscriminatory testing, procedural safeguards, classroom arrangement, IEPs, interest centers, and record keeping. The training may be delivered in many ways: e.g., workshops, one-on-one consultation, correspondence courses, conferences, audiovisual and print materials. Regardless of the method, delivery must be scheduled carefully, and it must accommodate language, cultural differences and customs. Finally, of course, all inservice training should be evaluated. Positive and negative feedback should be solicited so that the training's impact can be assessed and improvements made.

Community Awareness and Liaison

The entire preschool program must ensconce itself in the local community. This means that representatives of the program must communicate to various audiences. They must describe the needs of young exceptional children; share information about the preschool program (e.g., its mission, location benefits); raise funds to operate or maintain the program; and, advocate comprehensive coordinated services.

The preschool program must include goals for establishing and maintaining liaison with those local agencies and service providers that may affect handicapped children and families. These agencies include Head Start, social services, day care programs, BIA, hospitals, tribal agencies, and other private agencies.

What methods should be planned and implemented to create community awareness and maintain liaison relationships? Personal contact strategies are key to achieving objectives in this area. These include making presentations at public meetings, going "one-on-one" in private meetings, providing consultation, and building and using coalitions. In addition, print and audiovisual materials can be developed, as well as appropriate matter for the mass media (newspapers, radio, and TV). Of course, the messages delivered through various media or personal contact strategies must be tailored appropriately to the local community by using native language and referring to customs as necessary.

Program Setting and Transportation

Plans must be made for the environmental setting or facility for the program. These settings may vary. The preschool program may be operated in a home, in a center or classroom, in other community facilities, in distant locales, or in a combination of these settings. Depending upon the combination, designers may have to address a potpourri of concerns. For example, space arrangements, accessibility to the space, and furnishings may need to be planned. Appropriate audiovisual aids, texts, kits and other materials may have to be procured. Lighting, heating, cooling and acoustics may require attention. Lastly, safety against fire and playground hazards must be handled. All settings used should have supportive, caring, safe, and friendly atmospheres.

In order to see that children and families are able to participate in the preschool program and/or that service providers are able to reach the children and families, planners must see that adequate transportation arrangements are provided. This may entail providing automobile, bus or van, dog sled, or air services. These services may be available to families at no charge or there may be some form of reimbursement or cost sharing. It may be that in very isolated areas, transportation will have to give way to other strategies such as frequent telephoning or mail service.

Program Evaluation

A successful preschool program contains a component for ongoing evaluation. According to Cohen (1975), there are three reasons for program evaluation. First, it helps in both planning and revising the program; that is, evaluation provides information on which components to strengthen, eliminate, or add. Second, evaluation aids in administering and managing the entire preschool program -- i.e., child and family services, inservice training and community awareness. A manager needs to know if and when all planned services were delivered and at what cost. Finally evaluation provides a way to justify the program's value, worth or net effects on the children and their families.

Of course, evaluation as with the other preschool program components must be planned carefully. Goals, objectives, and areas to be evaluated must be specified. For example, child services, family participation, and inservice training may be monitored. Next, criteria need to be set for judging whether activities were achieved. Then, an evaluation design and reliable measures must be designated, the sequencing of evaluations planned, and data collection procedures determined. Finally, the results of the evaluation must be compiled, analyzed, and written-up clearly.

Preschool programs need to draw upon two types of evaluation: one, for monitoring the daily operations of the program, and another for tracking outcomes over a longer period of time. By incorporating these two schemes, the program should have more and better data for decision-making, improved staff communication, and indices of program effectiveness and efficiency.

Governance

The planning and implementation for this component will vary depending upon the program's sponsoring agency (i.e., tribe, school, native organization) and other factors such as locale, governance roles and functions, administrative placement of the program, and funding sources. For example, there may be a board of directors attached to a tribe which would actually provide a significant amount of overall programmatic direction. Or, there may be an advisory board from a native corporation education committee which provides advice on program matters such as transportation, funding, or community awareness. Finally governance may be tied directly to a structure such as a public school, BIA school, tribal or an Indian community-controlled school, cooperative school, junior college including an Indian community-controlled institution, or a college or university.

The role of governance must be articulated clearly: membership, function, policies, and scheduling must be clarified, meetings conducted; and the unique linguistic needs of members accommodated.

Financing and Business Affairs

The operation of a preschool program requires money that must be planned for and secured. More than likely, the major expenditure will be for staff salaries. Other costs may include space rental, equipment, telephone, transportation, food services, office supplies, postage, training and consultants, publicity, construction and renovation, and furniture.

A careful budget by cost categories needs to be planned in order to orchestrate the disbursements for expenditures. Budgeting allows preschool programs to weigh alternatives and make compromises as necessary. By all means, the budget must be justifiable and accountable.

To help managers get a feeling for some general costs, here are some examples. According to the Education Commission of the States (1971), it cost about one-and-a-half times more to serve a preschool child than an elementary school student. Other cost examples from the mid-1970s include: approximately $1700 per child, per year, are spent for a rural home-based program; about $2,000 per child, per year, are spent for serving hearing-impaired youngsters; approximately $2,600 per child, per year, are spent for a center-based program serving children with moderate to severe handicaps. These costs, which are higher in rural or isolated areas such as Alaska, have grown in the past few years because of inflation.

Funds for operating the preschool program can come from various sources. The following introduction is for funding sources that may be helpful in establishing, expanding, or maintaining programs for young Indian and Alaska Native handicapped youngsters.

Federal Funds. There are several sources that must be investigated. These include: the Handicapped Childrens Early Education Program in the Office of Special Education, U.S. Department of Education (for establishing area demonstration projects); Bilingual Education Classroom demonstration projects; Head Start; special Indian education programs and projects through the Office of Indian Education in the U.S. Department of Education and BIA.

State and Local Funds. Each community that considers starting, expanding, or maintaining a preschool program should explore the availability of state and local funds. Get to know the funding priorities and patterns of major agencies such as those working in mental health, native corporations, mental retardation, child development, tribal council, education, human resources, and town councils.

Private Funds. Fund raising in the community represents another source for generating revenue. It may be through such agencies as the United Way or through individual means such as bake sales or individual contributions. Also, local corporations, businesses or foundations may be contacted in order to solicit contributions.

Others. Endowments, in-kind donations, and fees from parents represent other sources that may need to be tapped.

Acquiring and managing funds will take a lot of work. So be prepared for a challenging and ongoing effort. A selected reference list of publications which deal with funding sources is available in Appendix G.

Administration, Management, and Coordination

The final component that must be planned and implemented represents the glue for holding together the entire preschool program. As Decker and Decker (1976) observed: "Adequate planning and administration will mean that the environment provided and the services rendered are efficiently managed in ways which are in keeping with the program's goals and the legal and/or funding agency's regulations and which are stimulating and supporting to those involved" (p. 7).

A host of different functions must be undertaken and coordinated. For example, there must be an administrative structure including a program director, staff and board of directors or advisory committee. Next there must be a procedure for setting the program's overall policies -- both day-to-day and long-term. These policies include such things as eligibility and admission requirements, service hours, program philosophy, hiring personnel, transportation, and staff-child ratios. Additionally, finances need to be managed, classroom or home-based operation supervised, inservice training held, families involved, community awareness and program evaluation executed. Finally, interagency agreements or contracts for related services must be developed, negotiated, and implemented.

To do all of these things and more requires a special effort and commitment. La Crosse (1979) reminds us that managerial skills are necessary, as well as honest, competent, and sensitive leadership for helping the preschool program pursue its goals and objectives.

CONCLUSION

Our ability to provide free, qualitative, and appropriate services, as well as those that are culturally and linguistically relevant, depends on carefully planning and implementing programs for exceptional preschoolers. There must be a problem-solving, decision-making process adopted to help guide the overall management of the program. By using a model, program designers and managers will be better able to pinpoint goals, develop budgets and determine constraints, generate and analyze different strategies, implement the best solution and evaluate its impact in terms of benefits and costs. Above all, there should be flexibility -- circumstances are subject to change.

Next, major influences on the preschool program must be identified and analyzed during preplanning. This activity then leads into the complex and often difficult task of articulating and agreeing upon the program's philosophy and goals. Finally, qualitative and sensitive leadership must orchestrate through action planning the construction, operation, and coordination of ten related program components.

Helping to assure success in these program-building and operation efforts is the work of a number of excellent program teachers and researchers who are beginning to compile lists of characteristics that lead to successful programs. McDaniels (1977) synthesizes his thinking by writing that successful programs are those that are coherent and include a rationale and clearly defined goals or expectations. Also, the timing of intervention (i.e., the earlier the better) and the amount of time required to reach goals are vital. Finally, according to McDaniels, "The success of any program rests in the hands of the care-givers: the parents, teachers, and other adults who deal directly with the child" (p. 31).

Another researcher and writer amplified these points. Anastasiow (1977) suggested that feelings of warmth, acceptance and positive reinforcement should prevail throughout the program. Additionally, he felt that the program must operate from a theoretical base, allow for adequate planning time and ongoing staff development. Finally, Anastasiow believed that success is related to a low child-to-teacher ratio, time for modeling, use of large amounts of language, and parental involvement.

Hopefully, this chapter has helped acquaint leadership personnel -- from public, BIA, tribal or Indian community-controlled educational units as well as Indian tribes and Alaska native corporations -- with the extensive facets of planning and implementing for preschool handicapped children and their families. As Foerster and Little Soldier (1977) observe, services to young Indian children are on the rise, with expanded early childhood efforts nationally, Head Start services, and kindergartens. Also, parents seem more receptive to these programs which have become more attractive and effective. Foerster and Little Soldier further believe that early intervention efforts "all seem noteworthy and represent a breakthrough for pupils who, for a variety of reasons, have fared poorly in the educational institutions of this nation and whose prognosis for success in school has, in the past, been dismal indeed" (p. 373).

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APPENDICES

APPENDIX A

INDIVIDUALIZED EDUCATIONAL PROGRAM

Required Components:
1. Child's present level of performance
2. Statement of annual goals
3. Short-term instructional objectives
4. Specific special education and related services to be provided and the extent to which child will participate in regular educational programs
5. Projected date for initiation and anticipated duration of services
6. Objective criteria and evaluation procedures and schedules for determining whether the short-term objectives have been met
7. Review of the IEP on an annual basis or more often when necessary.

Date of Placement
Committee Meeting ____________

PUPIL INFORMATION

Name: ____________ DOB: ________

Address: ____________ AGE: ________

____________ ZIP CODE ________

Sex: ____________

Telephone (home) ________ (work) ________

Grade/Program ____________

Date of Last Evaluation ____________

Student's Dominant Language ____________

Support Services: ____________

____

____

Participation in Regular Program: ____________

____

IEP TEAM

Sch. Admin. ____________

Parent: ____________

Teacher: ____________

____

____

____

____

Justification for Placement: ______

____

____

Present Level of Performance: ____________

____

____

ANNUAL GOALS: ____________________

LONG-TERM OBJECTIVES: ____________________

SHORT-TERM OBJECTIVES (State Activity and Criteria)	Beginning Date	Ending Date	Date Accomplished	Comments

Prepared By: ____________________

Date: ____________________

Child's Name________________ Date of Evaluation Report________________

Date________________

RECOMMENDATIONS ON EVALUATION REPORT:	FOLLOW-UP:
RECOMMENDATIONS FROM IEP MEETING:	

APPENDIX B

GLOSSARY OF SPECIALISTS

The following are some of the many kinds of professionals -- found in a variety of settings such as hospitals, clinics, schools, private practice, and special project programs -- who can and should become involved in the assessment, treatment and management of young children with special needs.

1. AUDIOLOGISTS are professionals trained in the services of hearing measurement who conduct screening and diagnosis of hearing problems and recommend procedures for the remediation of hearing loss as well as appropriate methods for communicating with a deaf or hearing-impaired child. An audiologist does not make a medical diagnosis of the ear but does determine the need for a hearing aid, assumes the responsibility for making a specific choice, fitting and managing its use.

2. CARDIOLOGISTS are medical doctors who conduct diagnosis, treatment and general management of disorders related to the heart. PEDIATRIC CARDIOLOGISTS specialize in the heart and circulatory problems of children.

3. DENTISTS are specialists responsible for the comprehensive dental care of individuals including examination and restoration of teeth as well as prevention and examination. PEDIATRIC DENTISTS are professionals who have received training in child psychology qualifying them to care for the needs of children and, often, the special problems of handicapped children. Both dentists may refer children to ORTHODONTISTS who specialize in correcting deformities of the mouth, principally the straightening and adjustment of teeth.

4. GENERAL PRACTITIONERS are medical doctors with wide general skills in the treatment and care of health problems who serve all family members.

5. NEUROLOGISTS are medical doctors who screen, diagnose, and treat disorders of the nervous system such as paralysis, reflect coordination, perceptual dysfunctions and others. They are particularly concerned with how the brain and the central nervous system influence behavior and development. They may refer children for electroencephalograms, a method of measuring electrical discharges of the brain, and other special medical procedures, and may, subsequently, prescribe medication for seizure disorders or hyperactivity. PEDIATRIC NEUROLOGISTS specialize in problems associated with the developing brain and nervous system of children.

6. NURSE PRACTITIONERS are nurses who have received special training to assess normal child development and to care for routine health problems that occur in children. They work under the supervision of a physician.

7. NUTRITIONISTS are professionals concerned with dietary habits who specialize in the body's use of food elements and their influence on human growth. Some disabled children are nutritionally vulnerable due to a variety of problems concerning food and nutrient intake. Others may require modified diets for diseases such as diabetes and allergies. A nutritionist may provide advice to parents and staff in various settings regarding basic nutritional principles related to the health and welfare of young children.

8. OCCUPATIONAL THERAPISTS are specialists concerned with the treatment of individuals having physical or mental disabilities through specific types of activities to promote development or rehabilitation. They work under the referral and guidance of a physician. PEDIATRIC OCCUPATIONAL THERAPISTS conduct developmental assessment of children, paying careful attention to fine motor and perceptual functioning, and often design programs to help some disabled children develop self-help skills for such every day tasks as self-feeding, toileting or dressing.

9. OPTHALMOLOGISTS are medical doctors who specialize in diagnosis and treatment of defects and diseases related to the visual acuity of the eye. Their treatment may include medication and eye surgery.

10. OPTICIANS are specialists who assemble corrective lenses and frames. They advise in the selection of frames and fit lenses prescribed by the OPTOMETRIST or OPTHALMOLOGIST to the frames and may also fit contact lenses.

11. OPTOMETRISTS are nonmedical degree specialists trained in the examination and assessment of visual acuity and treatment of vision problems through the use of glasses and/or exercises for the management of visual perception problems and related difficulties. They may examine, measure and treat eye defects by methods requiring no physician's license such as medication or surgery.

12. ORTHOPEDISTS are medical doctors who diagnose, treat and manage disorders related to the bone and skeleton of an individual's body. Orthopedists and orthopedic surgeons are concerned with the growth, repair and care of muscles, tendons, joints and bones and can provide invaluable assistance in correcting or ameliorating many conditions found among physically handicapped children.

13. OTOLARYNGOLOGISTS are medical doctors specially trained in treatment of diseases of the ear, nose and throat (ENT) and can provide invaluable management assistance for children with chronic problems in these areas.

14. OTOLOGISTS are medical doctors who specialize in the diagnosis, treatment and management of ear problems who also can provide invaluable management assistance for children with chronic problems of this organ.

15. PARENTS although noncredentialed are experts too!

16. PEDIATRICIANS are medical doctors skilled in the diagnosis and treatment of childhood diseases and in the general health care of children including assessment of normal child development.

17. PHYSICAL THERAPISTS are specialists concerned with the motor coordination of bones and muscles. They evaluate motor functioning and design exercises and activities to strengthen muscles and to prevent or correct deformities resulting from disease, injury or disability according to the prescription of a physician. The goal of a physical therapist is to make a physically disabled child as motorically independent as possible.

18. PSYCHIATRISTS are medical doctors who specialize in diagnosing emotional and interpersonal problems of individuals. Psychiatrists conduct interviews to determine mental status, emotional functioning and difficulties with interpersonal relationships. They can prescribe medication, manage treatment and carry out therapy for these same problems. CHILD PSYCHIATRISTS specialize in the emotional and social problems of children.

19. PSYCHOLOGISTS are specialists trained in the understanding of human behavior. They usually administer individual tests to determine the level of intellectual functioning or the overall development of an individual. While they do not have medical training and do not prescribe medication, psychologists may give treatment or psychotherapy for emotional or interpersonal problems. CHILD PSYCHOLOGISTS are professionals with special skills and understanding of the behavior, developmental and emotional problems of children.

20. PUBLIC HEALTH NURSES are registered nurses who are community based and are especially trained to survey, screen and manage community health problems or health problems in the home. They perform a variety of functions such as family counseling or setting up a treatment program in the home to work on feeding, toileting or sleeping routines of children.

21. RECREATION WORKERS are a group of professional therapists from the fields of music, art, including dance, and recreation who plan activity programs which are instructional and can improve the total life adjustment of special need individuals. Professionals in these fields use specific techniques in the area of their specialty for remediating or ameliorating mental and physical disorders and can be an invaluable adjunct to special services being provided for handicapped children (Fallen, 1978).

22. SOCIAL WORKERS are professionals with special training and experience in help people interact with their society as well as with family relationships, employment and finances. They help organize or coordinate a case study for other professionals and help families

make appointments for health, education and/or welfare services or seek out other community resources. Social workers often work with parents who need to talk about the impact of caring for special needs children.

23. SPECIAL EDUCATION TEACHERS are professionals with special training and experience in the education of exceptional children and youth with specific special needs. They may be teachers of the deaf or hearing-impaired, blind or visually handicapped, educable or trainable mentally handicapped, emotional and socially disturbed, crippled or health impaired-multihandicapped, specific learning disabled, and the gifted and talented. Members of this group may function as ITINERANT TEACHERS; they are educators who move about a community serving many schools within a district.

24. SPEECH AND LANGUAGE THERAPISTS are professionals who conduct screening, diagnosis and treatment of individuals who have communication disorders related to voice, language, articulation, oral motor skills and hearing. They design and/or conduct programs and exercises for children to improve the technical difficulties they may have in producing words and appropriate voice tone or to improve problems in word fluency, grammar or syntax.

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List of Information Organizations

1. Council for Exceptional Children

   1920 Association Drive
   Reston, Virginia 22091
   (703) 620-3660

2. Closer Look

   Parents' Campaign for Handicapped Children and Youth
   1201 16th Street, N.W.
   Washington, DC 20036
   (202) 833-4160

3. ERIC Clearinghouse on Handicapped and Gifted Children

   CEC
   1920 Association Drive
   Reston, Virginia 22091
   (703) 620-3660

4. National Association for the Education of Young Children

   1834 Connecticut Avenue, N.W.
   Washington, DC 20009
   (202) 232-8777

5. Office of Indian Child Services (Head Start)

   These offices are located in the following communities: Albuquerque (NM), Seattle (WA), Phoenix (AZ), Norman (OK), Anchorage (AK), Yankton (SD), and Billings (MT). Contact the one closest to you for more information.

CONTRACT

Between

ALASKA TREATMENT CENTER
FOR CRIPPLED CHILDREN & ADULTS, INC.

and

LOWER KUSKOKWIM SCHOOL DISTRICT

The Alaska Treatment Center for Crippled Children and Adults, Inc., hereinafter referred to as the Center, will provide school psychology services to the Lower Kuskokwim School District, hereinafter referred to as the District, in accordance with the following terms and conditions:

1. The Center's therapists shall be under the direct control and supervision of the District's Special Education Director and shall adhere to all District rules and regulations and procedures while in the District.

2. The Center shall:

   A. Provide evaluative and consultative services for up to 40 students from the Bethel area at the beginning of the school year.

   B. Provide continuing evaluative and consultative services for Bethel area students. A psychometrist/counselor shall be available 5 days/month, from October, 1978 through May, 1979 to accomplish this function. The psychometrist/counselor shall participate as a member of the Child Study Team as part of this function.

   C. Provide testing instruments and consumable testing materials.

   D. Provide typewritten, standard psychological reports regarding the students evaluated under this contract reflecting evaluation results and recommendations.

   E. Be responsible for assuring that quality services are provided and that these services are consistent with the ethics and standards of the profession.

3. The District shall:

   A. Provide the facilities necessary for proper administration and analysis of the evaluation, the C.S.T. process and for any report writing necessary while the psychometrist is in the District.

B. Schedule specific dates for services and inform the Center's psychometrist of the nature of the desired services at least two weeks in advance of the departure date to allow coordination of staff and schedules at the Center and to allow for proper selection of testing materials.

C. Handle all arrangements including payment, for trips from Bethel to surrounding villages and return.

D. Be responsible for bringing children to be evaluated to the testing facility.

E. Be responsible for obtaining written releases from the legal guardians of all children to be tested.

4. This contract shall be effective from September 1, 1978, through May 31, 1979, unless renewed upon such terms and conditions as may be agreeable to both parties.

5. This agreement may be modified by mutual agreement of the parties involved. Such modifications shall be reduced to writing and signed by both parties.

6. Either party may terminate this agreement by giving written notice, received by the other party at least thirty (30) days before the proposed termination date.

7. Services under this contract shall be billed on a monthly basis at the following rates:

Professional Services	$ 138.00 per child or $ 250.00 per day minimum consulting fee
Per Diem	$ 65.00 per day per person
Airfare	at cost

Total billings under this contract shall not exceed $20,000.00

8. INDEMNIFICATION: The District hereby agrees to indemnify, hold harmless, and defend the Center from any claims, demands, costs or judgment arising out of the failure of the District or any employee of the District to conform to the statutes, ordinances or orther regulations or requirements of any governmental authority in connection with operations carried out under this contract.

9. INDEMNIFICATION: The Center hereby agrees to indemnify, hold harmless, and defend the District from any claims, demands, costs or judgment arising out of the failure of the Center or any employee of the Center to conform to the statutes, ordinances or other regulations or requirements of any governmental authority in connection with operations carried out under this contract.

10. CONFORMITY TO LAW: This contract is to be governed by and construed according to the laws of the State of Alaska. If it should appear that any terms hereof are in conflict with any rule of law or statutory provision of any governmental authority having jurisdiction, then the terms of the contract which may be in conflict with the law shall be deemed inoperative and null and void, insofar as they may be in conflict therewith, and shall be deemed modified to conform to such rule of law.

DATE:____________________ __________________________________
Lower Kuskokwin School District

DATE:____________________ __________________________________
Alaska Treatment Center for Crippled Children and Adults

APPENDIX E

MEMORANDUM OF AGREEMENT BETWEEN THE BUREAU OF INDIAN AFFAIRS, BETHEL AGENCY AND THE LOWER KUSKOKWIM SCHOOL DISTRICT REGARDING AGENCY RESPONSIBILITY FOR PROVISION OF SPECIAL EDUCATION SERVICES TO PRESCHOOL HANDICAPPED CHILDREN

Whereas the BIA Federal Special Education funding formula does not include a reimbursement mechanism for provision of Special Education services to preschool handicapped children and,

Whereas Regional Educational Attendance Areas (REAA's) are eligible for PL 89-313, PL 94-142, PL 874, AND Alaska Special Education Foundation Funding reimbursement for provision of special education services to preschool handicapped children and,

Whereas, pursuant to AS 14.30.180 and AS 14.03.070, the state is responsible for providing competent education services for the exceptional child that is "at least three years of age and for whom the regular school facilities are inadequate or not available" this Memorandum of understanding between the BUREAU OF INDIAN AFFAIRS, Bethel Agency heretoafter referred to as the BIA and the LOWER KUSKOKWIM SCHOOL DISTRICT, heretoafter referred to as the LKSD, is entered into for the purpose of specifically delineating agency responsibilities for the delivery of child find, diagnostic, instructional evaluation, and related services for handicapped preschool children residing in villages that lie within the geographical boundaries of the LKSD, to wit:

1. The LOWER KUSKOKWIM SCHOOL DISTRICT, LKSD, will assume responsibility for the provision of basic diagnostic, instructional, evaluation and related services to identified handicapped children residing in villages that lie within the geographical boundaries of the LKSD.

   A. "Diagnostic Services" are limited to visual/audiometric screening, developmental screening, assessment of intellectual abilities, assessment of speech and language development, assessment of fine motor and gross motor development, and assessment of preacademic skills only.

   B. "Instructional Services" will include the development of a full services Individual Education Program (IEP) and, the provision of case-specific instructional personnel that will actually implement the IEP working directly with the child and his or her family. Instructional personnel will generally be in the form of part time Special Education Instructional Aides. These aides will be hired and trained by LKSD Special Education support personnel.

C. "Evaluation Services" will include the annual program reevaluation as required by PL 94-142. Such yearly evaluations will be conducted by the LKSD Special Education support personnel.

D. "Related Services" are limited to: Speech and Language therapy, occupational/physical therapy, diagnostic psychological services, and when possible audiometric services.

2. The LKSD will be responsible for insuring that all preschool handicapped children served will be afforded the due process rights during the evaluation, placement, and programming activities as guaranteed in PL 94-142.

3. In all phases of providing services to handicapped preschool children, the LKSD will adhere in its entirety to the ALASKA SPECIAL EDUCATION HANDBOOK 1978.

4. For purposes of this agreement, only those preschool handicapped children that are between three (3) and six (6) years of age and who do not attend a BIA of LKSD Kindergarten program will be eligible for Special Education services under this agreement. Children under the age of three (3), and children over six (6) years of age and children attending a formal school program are not eligible for services under this agreement.

5. The BUREAU OF INDIAN AFFAIRS, BIA will be one of the agencies responsible for conducting the Child Find aspect of the program implementation along with other agencies, such as the U.S. Public Health Service, Itinerant Nurses, PATCH (Professional Assistance Team for the Handicapped) and other appropriate agencies dealing with preschool children. The LKSD will provide technical support upon request. The BIA will act as a referral source and will notify the village Principals of their responsibility to refer suspected handicapped preschool children directly to the LKSD Special Education Department. All agencies initiating referrals will route referrals directly to the LKSD Special Education Department with copies forwarded to the BIA Bethel Agency Office.

6. The BIA will provide space for LKSD diagnostic support personnel to conduct screening and/or diagnostic activities. In addition when approved by the individual building principals, the BIA will provide, when possible; (1) working space for the BIA-Classroom Instructional Aide or other instructional personnel working with handicapped preschool children and (2) basic consumable instructional materials such as chalk, pens, paper and related materials.

7. The BIA will provide periodic on-site supervision and monitoring of instructional programs in all village sites requested by the LKSD. This periodic on-site program monitoring will be conducted by resident BIA Special Education personnel or by Itinerant BIA Special Education personnel during scheduled village visitations.

8. It is understood that the LKSD will count serviced preschool handicapped children on PL 89-313, PL 874, and the state foundation pupil accounting system. No other educational agency will duplicate count these children.

9. It is understood that there is no fiscal note between the BUREAU OF INDIAN AFFAIRS or the LOWER KUSKOKWIM SCHOOL DISTRICT tangent to this memorandum of understanding.

10. The LKSD will automatically transfer all IEP's and periodic IEP reviews of those preschool children who will be enrolling in a BIA school for the coming school year. This transfer of information will take place in January so that those handicapped students may be listed on the anticipated BIA student count for the coming school year.

DATE:	DATE:
Superintendent, Lower Kuskokwim School District	Superintendent for Education Bureau of Indian Affairs, Bethel Agency

The Professional Assistance Team for the Chronically Handicapped

An Exemplary Model of Cooperative Agency Interaction

by

Joseph S. Calderera

Bethel is a large Eskimo community located 400 air miles from the nearest city, Anchorage. Roughly 85 percent of the community are Yupik-speaking Eskimos. Bethel is the administrative center of the entire Yukon-Kuskokwim Delta which services fifty-seven villages in a 100,000 square mile area of southwestern Alaska. Within Bethel are the agency headquarters for twenty-five service delivery agencies. Federal, state, local and private agencies are represented in the agency network.

Historically, there has been considerable interagency overlap and duplication in the provision of services to the small corpus of chronically handicapped children. Oftentimes, the services provided by these agencies were conflicting, duplicating, and in many instances wasteful. It was a classic example of the left hand not knowing what the right hand was doing. Eventually, this random delivery system caused confusion, and, oftentimes significant interagency rivalry within the community.

In response to this problem, agency administrators for the primary service delivery agencies got together and developed a service consortium. The major objective of the consortium was to facilitate interagency cooperation in the delivery of direct and related services to handicapped children residing in Bethel and the surrounding fifty-seven villages. The consortium that resulted was named the Professional Assistance Team for the Chronically Handicapped or PATCH.

APPENDIX F/2

The Professional Assistance Team for the Chronically Handicapped is an interagency multidisciplinary team composed of the directors of the multiple agencies working with the handicapped children residing in the Yukon-Kuskokwim Delta area. The following agencies are represented in the PATCH network:

- Yukon-Kuskokwim Health Corporation
- Lower Kuskokwim School District
- US Public Health Services
- BIA Social Services
- Bureau of Indian Affairs Education Office
- Alaska State Itinerant Nursing Service
- Alaska Communicative Disorders Program
- Alaska Division of Corrections
- Jesuit Group Home

Other agencies (as required by the specific demands of individual client cases) also participate. They include Vocational Rehabilitation, Alaska Program for the Deaf, and the Alaska Program for the Blind/Visually impaired.

After the initial organizational meetings, the PATCH incorporated as a nonprofit corporate entity. A set of by-laws and operational procedures were developed by the member agencies. It was agreed upon that each month the PATCH network would conduct a formal organizational and staffing meeting. During this meeting individual children would be staffed utilizing the talents of the local multidisciplinary diagnostic treatment team. The PATCH conducted a considerable effort to develop a locally-based diagnostic capability. In so doing, a team of physicians, audiologists, psychologist, and a variety of other specialized personnel were developed to form the multidisciplinary assessment-diagnostic treatment team. The intent of the team was to develop a local capability for a full diagnostic and treatment services program that would free the community from its historical dependency on outside urban-based consultant teams. As a result of the efforts of PATCH, no longer do diagnostic teams have to come to the area to perform routine evaluations. There are, of course, the continued need for Specialty Clinics when outside consultants are brought in.

At each of the monthly meetings, the PATCH network staffs between three and twelve handicapped children. Parents are invited to the meetings and are integral participants in the interdisciplinary staffing. At these meetings, only those agencies that are directly involved in the student's case are participants in the Child Study Team Meeting. Integrated and nonoverlapping comprehensive therapeutic and diagnostic educational plans are developed and written at this multidisciplinary staffing. Timelines are established and areas of responsibility are clearly defined so that there is a minimum of delay and loss of energy implementing the direct service to the handicapped child.

The effect of this multidisciplinary staffing procedure has been that there is now a minimum of agency overlap and duplicating services in the area. In addition, agencies that have historically been at odds with one another are now cooperating on an unprecedented scale. The bottom line is that the handicapped children in this area have been the beneficiaries of this interagency cooperative service consortium. There is a considerable degree of interagency cross-referral which until the development of PATCH, was simply not done in this community.

The development of a Professional Assistance Team for the Chronically Handicapped simply involves the cooperation of agencies in the efficient utilization of resources and local talent. It requires that agencies engage actively in cooperative planning.

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The Bethel Professional Assistance Team for the Chronically Handicapped has been in operation for three full calendar years. Its overriding success has resulted in this area of the state having one of the most exemplary special education delivery systems in Alaska, if not in rural America. Overcoming some of the most forbidding environmental factors and historical animosity among agencies, the Professional Assistance Team for the Chronically Handicapped has bound the community together so that high quality specialized diagnostic and treatment services are administered to handicapped children of all ages on a routine basis.

APPENDIX G

Selected List of Publications Which Deal with Funding Sources

U.S. Government Printing Office. Catalog of Federal Domestic Assistance. Washington, DC: Superintendent of Documents, 1980.

Eckstein, B. Handicapped Funding Director: 1980-81. Oceanside, NY: Research Grant Guides, 1980.

Gilkerson, L. and Trohanis, P. Resources for Early Education Programs for Children with Handicaps. Chapel Hill, NC: Technical Assistance Development System, 1977.

Goltz, D. and Behrmann, M. Getting the Buck to Stop Here: A Guide to Resources for Special Needs. Reston, VA: Council for Exceptional Children, 1979.

McNulty, B. and Moreau, A. "Public and Private Funding Alternatives," Topical Paper #6. Seattle, WA: Western States Technical Assistance Resource at the University of Washington, (April) 1980.